

Osteopathic Physician Assistant License Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Osteopathic Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms required.

Application Fee. This fee is non-refundable. You can check the online [fee page](#) for current fees.

Select if the following applies:
Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information:
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

2. Personal Data Questions:

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

3. Professional Education:

List in date order, most recent to later, your educational preparation and post-graduate training. Attach additional pages if you need more space.

4. Professional Experience:

List in date order, most recent to later, all your professional experience and practice from date of graduation from professional college. Attach additional pages if you need more space.

5. Previous Licenses:

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. Attach additional pages if you need more space.

6. Hospital Privileges:

List hospitals in the U.S. where hospital privileges have been granted within the past five years. Attach additional pages if you need more space.

- Verifications must be received directly from each hospital.
- Verification for military hospital privileges may be obtained by the current duty station or, if no longer in active service, National Personnel Records Center, Military Personnel Records, 1 Archives Dr, St Louis MO 63138.
- Locum Tenens: Hospital privileges of a 30-day or longer duration.

7. AIDS Education and Training Attestation:

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in [WAC 246-12-270](#). If AIDS education was included in your professional education or training, an additional course is not required.

8. Applicant’s Photograph:

Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and front view. Your application will not be processed without a current photograph.

9. Applicant’s Attestation:

You must sign and date this for us to process the application.

License Requirements

To qualify for your license, you must have graduated from a program approved by the board.

“Board approved program” means a physician assistant program accredited by:

- The Committee on Allied Health Education and Accreditation (CAHEA).
- The Commission on Accreditation of Allied Health Education Programs (CAAHEP).
- The Accreditation Review Committee on Education for the Physician Assistant (ARC-PA).
- Any successor accrediting organization using the same standards.

You must also pass the National Commission on Certification of Physician Assistant (NCCPA) examination within one year of graduation from a physician assistant program.

If you hold an active allopathic physician assistant license:

See [WAC 246-854-082](#)

- Your Washington State license as a allopathic physician assistant must be active and unrestricted.
- Submit an osteopathic physician assistant application and [fee](#).
- A delegation agreement must be completed and approved by the board prior to beginning practice.

Note: You may not begin to practice as a osteopathic physician assistant until your delegation agreement has been approved and your credential has been issued.

Initial applicants

Submit the following documents:

- Transcripts sent directly from your physician assistant program.
- Verification letters sent directly to the board from all hospitals where you were granted privileges with in the past five years. If your last employment was in Washington State, verify any hospital privileges you had during your last practice relationship.
- Verification letters sent directly from all states in which you have ever obtained a license to practice as a health care professional. Any Washington license will be verified directly from our data base. Some states require a processing fee. Check with each state to determine this fee.
- Verification of the National Commission on Certification of Physician Assistants, (NCCPA) examination. Show on the application if you are certified. Verification of certification will be obtained by staff.

- A delegation agreement must be completed and approved by the board prior to beginning practice. If you are no longer working with an osteopathic physician supervisor you may either renew your license or let it expire. Keep in mind there will be more fees to reactivate your license in the future. You cannot practice in Washington without a license and delegation agreement with a supervising physician approved by either the board of Osteopathic Medicine and Surgery (osteopathic physician - DO) or the Medical Quality Assurance Commission (allopathic physician- MD).

Note: All documents must be originals. Copies or faxed documents will not be accepted.

Interim Permit

An interim permit may be issued until the NCCPA certification has been obtained but no longer than one year. Upon receipt of the NCCPA certification, notify the board, and submit the fee to be issued a full license. You are required to have more frequent supervision, limited prescribing authority, and can not practice in a remote site. An interim permit is issued for one year and cannot be renewed.

Delegation agreement Application

Submit the following documents:

- Complete the Osteopathic Physician Assistant application form and submit the documents required for an original license or have a current osteopathic physician assistant license.
- Completed delegation agreement.
- If you transfer from a Washington physician supervisor (either MD or DO), you must have verification letters sent directly from all hospitals where you were granted privileges during the past working relationship.
- Letter of evaluation from previous supervising physician.

Prescriptive Authority

A certified osteopathic physician assistant or interim permit holder can issue written or oral prescriptions as provided in [WAC 246-854-030](#) when approved by the board and assigned by the supervising physician.

Supervision and Practice Responsibility

The supervising osteopathic physician is responsible for adequate supervision and review of the osteopathic physician assistant's work. Only those tasks authorized by the board may be performed by the osteopathic physician assistant.

In the temporary absence of the supervising osteopathic physician, the osteopathic physician assistant may carry out those tasks for which they are licensed, if a delegated alternate physician supervisor or physician group provides supervision and review. The osteopathic physician assistant may not function if delegated alternate supervision and review are not available.

An M.D. can be the alternate supervisor for an osteopathic physician assistant licensed under the board.

The physician assistant can not advertise or mislead the public and must wear an identifying badge in a prominent place when meeting or treating patients.

See [WAC 246-854-015\(5\)\(e\) and \(f\)](#).

Following termination of supervision, the supervising physician and the osteopathic physician assistant must notify the board in writing within 30 days of the termination and include an explanation.

More Information

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required. If your application is incomplete, you will be mailed or emailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Put N/A or place a line through a section instead of leaving it blank.
- You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

To receive notifications regarding the profession, please join our [List-Serv](#).

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
 - A copy of your marriage certificate to show proof of marriage; or
 - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?
 - b. Diverted controlled substances or legend drugs?
 - c. Violated any drug law?
 - d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?

3. Professional Education

List in date order, most recent to later, your educational preparation and post-graduate training. Attach additional pages if you need more space.

Schools Attended Full Name, City and State	Degree Earned	Dates Granted	
		Start (mm/yyyy)	End (mm/yyyy)

4. Professional Experience

List in date order, most recent to later, all your professional experience and practice from date of graduation from professional college. Attach additional pages if you need more space

Name of Business	Total Number of Months	Type of Experience

5. Other License, Certification, or Registration

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. Attach additional pages if you need more space.

State Jurisdiction	Profession	License		Licence Method		Currently Enforce
		Year	Number	Exam	Other	
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>

6. Hospital Privileges

List hospitals and locations where admitting privileges have been granted within the past five years. Attach additional pages if you need more space.

Name of hospital (For locum tenens, enter only those of a 30-day or longer duration).	Dates attended	
	Start (mm/yyyy)	End (mm/yyyy)

7. Aids Education and Training Attestation

I certify that I have completed a minimum of seven hours of education in the prevention, transmission, and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information my license may be denied, or if issued, suspended or revoked.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's initials	Today's Date

8. Applicant's Photograph

Photo Here



Attach current photograph here. Indicate date taken and sign in ink across bottom of the photo.

NOTE: Photograph **must** be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view of applicant
5. Instant polaroid photographs **not** acceptable

Height _____

Weight _____

Hair color _____

Color of eyes _____

9. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of Washington that the following is true and correct:
(Print applicant name clearly)

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ By: _____
(mm/dd/yyyy) (Original signature of applicant)



Osteopathic Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Osteopathic Physician Assistant Delegation Agreement

Name of Physician Assistant		NCCPA Certification #	License # if applicable
Business address			
City		State	Zip Code
Phone (enter 10 digit #)	Email Address		County
Primary Supervising Osteopathic Physician (DO Only) (Required)			
Physician name		Specialty	License #
Business address			
City		State	Zip Code
Phone (enter 10 digit #)	Email Address		County
Alternate Supervisor (DO or MD)			
Physician name		Specialty	License #
Business address			
City		State	Zip Code
Phone (enter 10 digit #)	Email Address		County
Physician Group			
Business Name			
Business address			
City		State	Zip Code
Contact Name		Contact Phone #	
Contact Email Address		Medical Staff Office Phone #	

Standardized Procedures Reference and Guidelines

Responsibility:

The supervising physician and Osteopathic Physician Assistant (PA) are both professionally and personally equally responsible for any act performed by the PA as it relates to the practice of medicine.

Supervision of the PA by the physician is the defining hallmark of PA practice and is viewed by physicians and PAs as the major strength of their professional relationship.

Scope of Practice:

PAs may only provide those services that they are competent to perform based on their education, training, and experience and which are consistent with this delegation agreement. The supervising physician and the PA shall determine which procedures may be performed and the degree of supervision under which the PA performs the procedure.

No physician who is designated as a supervising or alternate physician for any PA shall allow that PA to practice in any area of medicine or surgery that is beyond the physicians own usual scope of expertise and practice.

An Interim Permit holder may not practice in remote sites.

Physician Assistant Supervision:

The primary supervisor and the physician assistant must agree upon a plan of supervision based on the physician assistant's training and experience. Specified record reviews and periodic performance evaluations must be part of that plan. Adjustments to the plan must reflect the physician assistant's on-going practice.

Prescriptive Authority:

This delegation agreement allows the PA to prescribe, to order, to administer and to dispense legend drugs and Schedule II-V controlled substances. If a supervising or alternate physician's prescribing privileges are restricted, the PA will be deemed similarly restricted.

Practice Site: (Mark all that apply.)

A. The PA will be in the same practice site as the supervising physician. When the PA assistant is on duty, the supervising physician or the alternate physicians or physician member of the group practice will be available for on-site supervision or telephone consultation at all times.

B. The PA will be practicing in a remote site. **If applicable, complete the attached Remote Site Request Form.** Individuals holding an Interim Permit may not practice in a remote site. A remote site is defined as a setting physically separate from the supervising physician's primary place for meeting patients. Or a setting where the physician is present less than twenty-five percent of the practice time of the licensee.

[\(RCW 18.57A.035\)](#)

Practice Sites	% of time in a week PA spends at each setting
Primary Care or Specialty Care Clinic	
Mental Health Facility	
Chemical Dependency Settings	
Home Visit	
Hospital	
Correctional Facility	
Ambulatory Surgical Center	
Adult Family Home Visits	
Nursing Home/Rehabilitation	
Free Standing Urgent Care Clinics	
Emergency Rooms	
Retail Clinics	
Medical Spas	
Hospice Care	
Occupational Medicine	
Other – Please describe	

Practice Arrangements

1. Describe the duties to be performed by PA in each of the practice settings selected above. (Attach additional paper if necessary)

2. Supply a detailed plan for supervision and chart review as required in [WAC 246-854-021\(2\)](#).

3. No physician may supervise more than five PAs without written authorization by the Board. See [RCW 18.57A.040](#). If approval of this delegation agreement results in the supervision of more than five physician assistants, please explain the necessity.

Periods of Absence/Vacation

When the supervising physician is away from the office or practice location for any period of time, including vacation, continuing education or illness:

Check one

A designated alternate physician will supervise the PA at all times in accordance with this practice description.

The PA will cease to function as such, as no alternate supervisor has been designated.

Other Current Practice Plans:

1. List by name all PAs this physician currently supervises.

2. List by name all the physicians with which this PA has a current delegation agreement.

Termination:

If this delegation agreement is terminated, the board must be notified in writing of that termination by either a letter or email. See [WAC 246-854-021\(8\)](#).

Send notification to:

Osteopathic Credentialing
PO Box 47877
Olympia, Washington 98504

Email: HSQACredentialing@doh.wa.gov

Fax: 360-236-4918

We hereby certify under penalty of perjury under the laws of the State of Washington that the foregoing information in this delegation agreement is correct to the best of our knowledge and belief. We further certify we have reviewed the current rules and regulations of the Board of Osteopathic Medicine and Surgery pertaining to osteopathic physician assistants and this practice description and understand our roles and responsibilities.

Signature of Osteopathic Physician Assistant

Date

Signature of Supervising Osteopathic Physician

Date

Signature of Alternate Physician

(Only required if single alternate supervisor is listed.)

Date

Retain a copy of this delegation agreement as reference and guide for review by a Department of Health representative in the event of a site-review visit.



Washington State Department of
Health
 Osteopathic Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Osteopathic Physician Assistant Remote Site Request Form

A remote site is a practice location where the osteopathic physician is present less than 25% of the practice time of the certified osteopathic physician assistant. See [RCW 18.57A.035](#).

Name of Physician Assistant		License #
Primary Supervisor Name		License #
Name of Remote Site		Phone (enter 10 digit #)
Address of remote site		
City	State	Zip Code

Remote Site Practice Questions:

1. Will the Osteopathic Physician Assistant practice in more than one remote site setting? Yes No
 If yes, list all remote sites. If more than two remote sites, please attach additional pages.

Practice Sites (Please mark all that is applicable to this request.)	What percentage of time per week does the Osteopathic PA spend at each setting?	What percentage of time per week does the supervising physician spend at each setting?	What percentage of time per week are the supervising physician at each setting at the same time?
Supervising physician's primary practice site:			
Remote Site Address:			
Remote Site Address:			

1. Supply a detailed plan for supervision and chart review as provided in [WAC 246-854-015](#).

2. Include an explanation of the community need for utilization of the osteopathic physician assistant in the remote site. (Please see [WAC 246-854-025](#) Remote Site.)

3. Explain the arrangement made for the osteopathic physician and certified osteopathic physician assistant to communicate in emergent situations.

We hereby certify under penalty of perjury under the laws of the State of Washington that the foregoing information in this delegation agreement is correct to the best of our knowledge and belief. We further certify we have reviewed the current rules and regulations of the Board of Osteopathic Medicine and Surgery pertaining to osteopathic physician assistants and this practice description and understand our roles and responsibilities.

Signature of Osteopathic Physician Assistant

Date

Signature of Supervising Osteopathic Physician

Date

Signature of Alternate Physician
(Only required if single alternate supervisor is listed.)

Date

Retain a copy of this form as reference and guide for review by a Department of Health representative in the event of a site-review visit.



Washington State Department of
Health
Osteopathic Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Hospital Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
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I have applied for a license to practice osteopathic medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my hospital privileges and return it the address listed above.

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Osteopathic Medical Board.

Signature of Applicant:	Date (mm/dd/yyyy):
-------------------------	--------------------

1. Does the applicant have, or has he/she ever had, admitting or specialty privileges at your hospital?

Yes No Beginning Date: _____ Ending Date: _____

2. Have the applicant's privileges ever been restricted, suspended or revoked by the medical staff or administration, or in any status other than good standing? Yes No If so, for what reason?

3. Has the applicant ever been asked to resign or surrender any privileges voluntarily in lieu of or to avoid adverse action?

Yes No If so, for what reason? _____

Name:	Title:
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Facility:	Phone (enter 10 digit #):
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Address:

Authorized Signature:	Date:
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Washington State Department of

Health

Osteopathic Credentialing

PO Box 47877

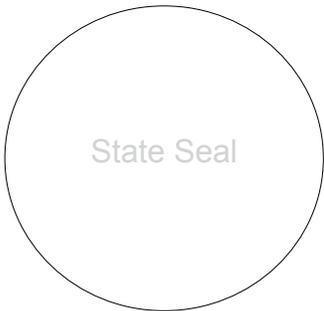
Olympia, WA 98504-7877

360-236-4700

State License Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
<p>I have applied for a license to practice osteopathic medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my state license and return it the address listed above.</p> <p>Please reply as soon as possible to avoid delays in the licensing process.</p> <p>I hereby authorize you to release the following information to the Washington State Osteopathic Medical Board.</p>	
Signature of Applicant:	Date (mm/dd/yyyy):

To assist the Washington State Board in evaluating the above osteopathic physician's application, we would appreciate receiving the following information.	
License Number:	Date license was issued:
Status of License:	<input type="checkbox"/> Active <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Inactive <input type="checkbox"/> Expired
Has the applicant's license ever been suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any other disciplinary or corrective active been taken?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the licensee surrendered the license in lieu of disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have answered yes to any of the questions above, attach supporting documentation pertaining to disciplinary orders or any other actions.	



State Board:	
Address:	
Phone (enter 10 digit #):	
Authorized Signature:	Date:

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RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Osteopathic Physician Assistant Laws, RCW 18.57A](#)

[Osteopathic Physician Assistant Rules, WAC 246-854](#)

Continuing Education

[Osteopathic Physician Assistant Continuing Medical Education, WAC 246-854-110](#)

[Categories, WAC 246-854-115](#)

Online

[Board of Osteopathic Medicine and Surgery, Web page](#)