



## **Osteopathic Physician and Surgeon Inactive License Activation Application Packet**

### **Contents:**

1. 663-069 ..... Contents List/SSN Information/Mailing Information..... 1 page
2. 663-059 ..... Application Instructions Checklist ..... 3 pages
3. 663-060 ..... Osteopathic Physician and Surgeon License Activation Application ..... 3 pages
4. 663-037 ..... Hospital Investigative Letter ..... 1 page
5. 663-038 ..... State Licensure Investigative Letter ..... 1 page
6. RCW/WAC and Online Website Links ..... 1 page

### **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, contact the Customer Service Center at 360-236-4700 for more information.

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 your check or money order payable to:**

Department of Health  
PO Box 1099  
Olympia, WA 98507-1099

**Send additional documents to:**

Osteopathic Credentialing  
PO Box 47877  
Olympia, WA 98504-7877

**Contact us:**

360-236-4700

(This page intentionally left blank.)

## Application Instructions Checklist

You will be notified in writing if further documentation is required.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- Pay Late Penalty Fee.**
- Pay Current Renewal Fee.**
- Pay Expired Credential Reissuance Fee.**  
**All fees are non-refundable.** These fees are located on the Board of Osteopathic Medicine and Surgery online [fee page](#).
- 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 credential. Be sure to include the city, state, zip code, county and country. This will be your permanent address with 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 applicable.

**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. Other License, Certification, or Registration.** List **all** credentials you have held since last being credentialed in Washington State. List in date order, most current first. Include your last active credential in Washington State. Attach additional pages if you need more space.
- 3. Professional Experience.** In date order, list all your professional work experience since your Washington State credential expired. Attach additional pages if you need more space.
- 4. 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.
- 5. Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- 6. Continuing Education Attestation.** Required by [WAC 246-12-040](#).
- 7. Hospital Privileges.** List the hospitals where privileges have been granted in the past five years.
- 8. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

## **Additional Documentation Required For Activation.**

- Professional Liability Action History.**  
Malpractice information pertaining to any civil suit or judgment in connection with the practice of a health care profession. Include the nature of the case, date and summary of the care given, and settlement amount. The applicant must provide a summary of each case, and include copies of the settlement or final disposition. If pending, indicate status. If the case is rather old, you should be able to contact the county where it was filed to get the documentation. Please attach a piece of paper.
- State Licensure Verification.**  
Applicants must verify all osteopathic medical licenses that he or she holds, or has held, in any other state, territory or possession of the United States or Canadian province since the expiration date of your previous Washington State credential. Verification is required whether the license is active or inactive. This includes temporary and training licenses. Applicants should contact the state licensing authority for information regarding fees for verification of licensure. Form provided.
- Hospital Privileges.**  
Applicants must verify all hospitals where admitting or specialty privileges have been granted in the last five years. Verification must be received directly from the hospital. All hospital privileges connected with military practice experiences may be verified by the current duty station or, if no longer in active service, the appropriate agency of record or National Personnel Records Center, Military Personnel Records, 1 Archives Dr, St Louis MO 63138. Form provided.
- Federation of State Medical Boards Data Bank Clearance.**  
The Board requests verification of any disciplinary actions directly from the Federation.
- American Osteopathic Association Physician Profile.**  
The Board requests education and training profiles directly from the AOA.

The process of re-activation will involve retrieval of your previous credential file from the state records center. The retrieval time period is approximately two weeks. Pursuant to [WAC 246-853-025](#) a reactivation applicant may be required to take a special purpose examination.

Once the abbreviated application is considered complete, it will be referred for review. All information, documents data, etc., provided to the department by the applicant is to be submitted in writing and will become part of the file. Telephone information will not be accepted in place of written documentation. The department may conduct additional investigation of irregular information contained in the file or documentation by contacting primary sources or other agencies as necessary to verify application information. Primary source documentation must be original, faxed documents will not be accepted.

(This page intentionally left blank.)

Date  
Stamp  
Here

Revenue 0232070000

## Osteopathic Physician and Surgeon Inactive License Activation Application

Please print clearly. Follow the instructions provided. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

### 1. Demographic Information

**Social Security Number (SSN)**  
(If you do not have a SSN, see instructions)

**National Provider Identifier Number (NPI)**  
(Enter 10 digit number)

Male  
 Female

Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)	<b>Place of birth</b>		
	City	State	Country

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
--------------------------	------------------------	-------------------------

Email address

Mailing address of record (if different from above)

City	State	Zip Code	County
------	-------	----------	--------

Country

**Note:** The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)?  Yes  No

If yes, list name(s):

Will documents be received in another name?  Yes  No

If yes, list name(s):

## 2. Other License, Certification, or Registration

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently In Force	
		Type	Number	Year Issued		No	Yes

## 3. Professional Experience

Type of experience of practice and location	Start (mm/yyyy)	End (mm/yyyy)

## 4. AIDS Education and Training Attestation

I certify I have completed the 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

## 5. Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

APPLICANT'S INITIALS

## 6. Continuing Education/Continuing Competency Attestation (If you have one)

I certify that I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all classes attended/claimed.

APPLICANT'S INITIALS

## 7. Hospital Privileges

List hospitals and locations where privileges have been granted within the past five years.

Name of Hospital and Location	Dates	
	Start (mm/yyyy)	End (mm/yyyy)

## 8. 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)

(This page intentionally left blank.)



Washington State Department of  
**Health**  
 Osteopathic Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Hospital Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
-----------------------------------	--------------------------

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 has he/she ever been asked to resign?  Yes  No If so, for what reason?  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Has the applicant ever been asked to resign or surrender any privileges voluntarily in lieu of action being taken?  
 Yes  No      If so, for what reason? \_\_\_\_\_  
 \_\_\_\_\_

4. Is there any information in your files that could call into question the applicant's ability to safely practice osteopathic medicine and surgery?  Yes  No If yes, explain.  
 \_\_\_\_\_  
 \_\_\_\_\_

Please attach any copies of information in your records that would provide further information.

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

(This page intentionally left blank.)

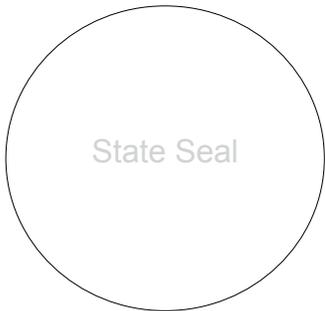


Washington State Department of  
**Health**  
 Osteopathic Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## 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):

<p>To assist the Washington State Board in evaluating the above osteopathic physician's application, we would appreciate receiving the following information.</p>	
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:

(This page intentionally left blank.)

## **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 Medicine and Surgery Laws, RCW 18.57](#)

[Osteopathic Medicine and Surgery Rules, WAC 246-853](#)

### **Continuing Education**

[Osteopathic Continuing Medical Education Rules, WAC 246-853-060-090](#)

### **Online**

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