



## **Osteopathic Physician Assistant Expired License Activation 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, 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 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.

**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. Education.** List in date order, most recent to later, your educational preparation and post-graduate training. Attach additional pages if you need more space.
- 3. 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.
- 4. Other License, Certification, or Registration.** List all states where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional pages if you need more space.
- 5. Hospital Privileges.** List hospitals in the U.S. where hospital privileges have been granted within the past five years. Attach additional completed 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, the Human Resource Command, 1 Reserve Way, St. Louis, MO 63132.
  - Locum Tenens: Hospital privileges of a 30-day or longer duration.
- 6. 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](#).
- 7. 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.
- 8. Applicant's Attestation.** You must sign and date this for us to process the application.

## **Delegation Agreement Application**

- 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.

[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 at: [List-Serv](#).

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Date  
Stamp  
Here

Revenue 0252120000

## Osteopathic Physician Assistant Expired 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

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name	First	Middle	Last
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Birth date (mm/dd/yyyy)	<b>Place of birth</b>		
	City	State	Country

Address

City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address of record (if different from above)

City	State	Zip Code	County
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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. Education

List in date order, most recent to later, your educational preparation and post-graduate training.

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

## 3. Experience

List in date order, most recent to later, all your professional experience and practice from date of graduation from professional college.

Name of Business	Total Number of Months	Start (mm/yyyy)	End (mm/yyyy)

## 4. Other License, Certification, or Registration

List all states where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current.

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

## 5. Hospital Privileges

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

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

## 6. 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.**

Applicant's initials	Date
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## 7. 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 \_\_\_\_\_

## 8. Applicant's Attestation

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

- 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 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 \_\_\_\_\_ at \_\_\_\_\_  
(mm/dd/yyyy) (City, state)

By: \_\_\_\_\_  
(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
<b>Primary Supervising Osteopathic Physician (DO Only) (Required)</b>			
Physician name		Specialty	License #
Business address			
City		State	Zip Code
Phone (enter 10 digit #)	Email Address		County
<b>Alternate Supervisor (DO or MD)</b>			
Physician name		Specialty	License #
Business address			
City		State	Zip Code
Phone (enter 10 digit #)	Email Address		County
<b>Physician Group</b>			
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 physician's 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)

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

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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.

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## 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.

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

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### 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](mailto: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.

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Signature of Osteopathic Physician Assistant

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Date

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Signature of Supervising Osteopathic Physician

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Date

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Signature of Alternate Physician

(Only required if single alternate supervisor is listed.)

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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.



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:

- 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](#).

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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.)

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

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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.

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Signature of Osteopathic Physician Assistant

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Date

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Signature of Supervising Osteopathic Physician

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Date

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

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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.



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):
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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:
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Authorized Signature:	Date:
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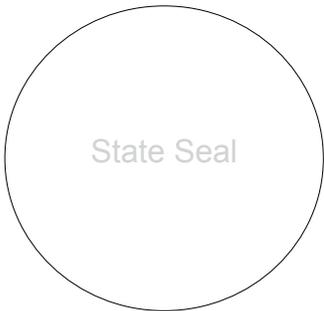


Washington State Department of  
**Health**  
 Osteopathic Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## 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):

<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:

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## **RCW/WAC and Online Web Site 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](#)