Washington State Department of Health

Physical Therapist Assistant Expired Credential 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
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Board of Physical Therapy
Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Washington State Department of Health

Application Instructions Checklist

You will be notified in writing if more documentation is needed.

To ensure 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.** You can check the **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 city, state and country where you were born.

  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 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. Other License, Certification, or Registration.** List in date order, most recent to later, **all** your credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. Attach additional pages if you need more space.

- ☐ **3. Professional Experience.** List in date order, most recent to later, 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.** Required by **WAC 246-12-040**. 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. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

Washington State Department of Health

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Physical Therapist Assistant Expired Credential Activation Application

Please print clearly. 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)	**Place of birth**		
	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 if different from above address of record			
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 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 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	Date

6. Continuing Education/Continuing Competency Attestation

I certify that I have met all continuing education (40 hours) and competency (200 employment hours) requirements for the past two years.

Applicant's Initials	Date

7. 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 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)

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Physical Therapy Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. Instruct them to return the form directly to the address listed above. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

Name Last	First	Middle
Mailing Address		
City	State	Zip Code
Any other names used		
Type of healthcare license, certification, or registration		
License, Certification, or Registration Number	Date Issued	

Have the licensing agency return this completed form to the address listed above.

If you have any questions, please call 360-236-4700.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of license, certification, or registration holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by: ☐ Written Examination	Date:	Score:
Name of examination:		
☐ Other Examination	Date:	Score:
Name of examination:		
Is credential current: ☐ Yes ☐ No	Expiration Date:	
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no," please attach explanation.		
Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ No If "yes," please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No		

(SEAL)

Signature:

Title:

Date:

Washington State Department of Health

RCW/WAC and Online Website Links

RCW and WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Physical Therapy Laws, RCW 18.74

Physical Therapy Rules, WAC 246-915

On-Line

AIDS Training Resources, Reference Page

Board of Physical Therapy, Web Page

Federation of State Boards of Physical Therapy, (FSBPT), www.fspbt.org