

# Social Worker Associate Independent Clinical License Application Packet

#### **Contents:**

1.	670-105Contents List/SSN Information/Mailing Information	1 page
2.	670-106 Application Instructions Checklist	3 pages
3.	670-107License Application	5 pages
4.	670-108Out-of-State Credential Verification Form	2 pages
5.	670-109 Approved Supervisor Verification	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, 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:

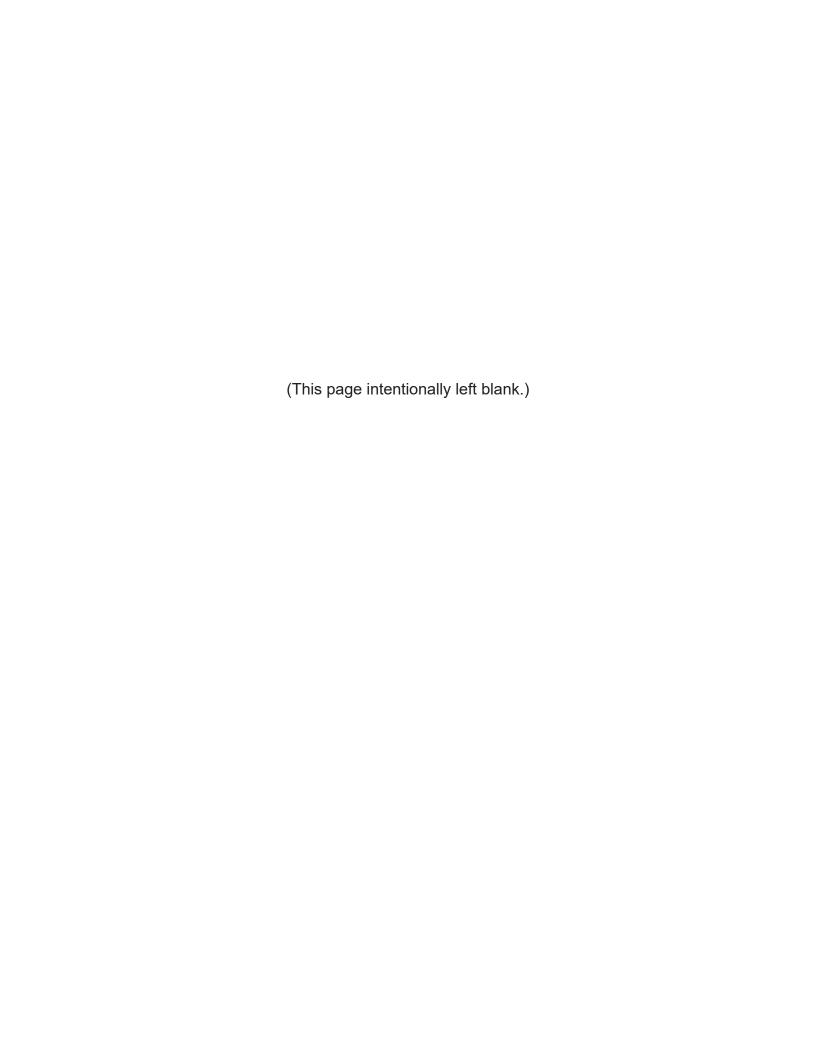
Department of Health P.O. Box 1099 Olympia, WA 98507-1099 Send other documents not sent with initial application to:

Social Worker Associate Credentialing P.O. Box 47877 Olympia, WA 98504-7877

#### **Contact us:**

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email <a href="mailto:civil.rights@doh.wa.gov">civil.rights@doh.wa.gov</a>.





# **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

mit the required forms.
<b>Application Fee.</b> This fee is non-refundable. You can check the online <u>fee page</u> for current fees. This fee may be paid by a personal check or money order, payable to the Department of Health.
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.
<b>National Provider Identifier Number (NPI):</b> 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.

**Address:** List the address we should use to send any information on 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**.

DOH 670-106 June 2020 Page 1 of 3

П	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 questions. If you do not provide this, your application is incomplete and it will not be considered.
	<ul> <li>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.</li> </ul>
	<ul> <li>If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.</li> </ul>
	<ul> <li>Another jurisdiction means any other country, state, federal territory, or military authority.</li> </ul>
	3. Education: List your educational preparation. Graduation with a master's or doctoral social work educational program accredited by the Council on Social Work Education and approved by the secretary based upon nationally recognized standards.
	<b>Transcripts:</b> Your school must send official school transcripts directly to the Social Worker Associate Credentialing.
	4. Other License, Certification, or Registration: List all states, including Washington, where credentials are or were held.
	An Out-of-State Credential Verification Form is enclosed and must be sent to each state you listed. Enter your full name and birth date at the top of the form so the state can identify you. Also, contact each state board listed for any fees they may charge you for processing the verification.
	<ol><li>Declaration Working Toward Licensure:</li><li>Declare that you are working toward licensure as a Social Worker.</li></ol>
	6. Applicant's Attestation: You must sign and date this for us to process the application.

DOH 670-106 June 2020 Page 2 of 3

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.

 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.

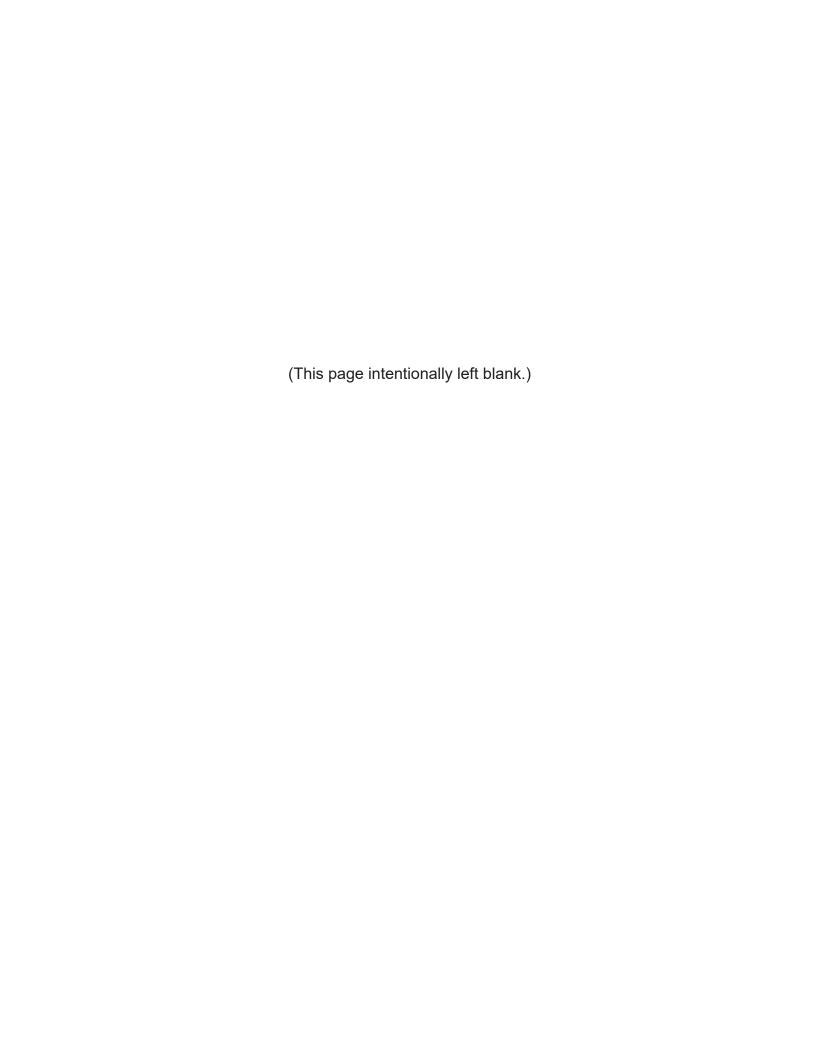
# For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

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.

DOH 670-106 June 2020 Page 3 of 3





Date Stamp Here

Revenue: 0207041000

Social Worker Associate Independent Clinical License Application							
Select if the following applies:							
1. Demographic Inform	ation						
Social Security Number (SSN) (If you do not have a SSN, see instructions)		National Provider (Enter 10 digit number	Identifier Number (NPI) er)	☐ Male ☐ Female			
Name First		Middle	Last				
Birth date (mm/dd/yyyy)							
Address							
City	State	Zip Code	County				
Country	1						
Phone (enter 10 digit #)	Phone (enter 10 digit #)  Fax (enter 10 digit #)  Cell (enter 10 digit #)						
Email address							
Mailing address if different from abo	ve address of re	ecord					
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)?							
Will documents be received in another name?							

DOH 670-107 June 2020 Page 1 of 5

2.	Pe	ersonai	Data	Questions	Yes	No		
1.	•			ndition which in any way impairs or limits your ability to practice your e 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.							
-	<ol> <li>How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.</li> </ol>							
	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.							
		psycholo application examinat based on required	gical exactor, you go ion report confider examination	hority may require you to undergo one or more mental, physical or amination(s). This would be at your own expense. By submitting this give consent to such an examination(s). You also agree the ort(s) may be provided to the licensing authority. You waive all claims intiality or privileged communication. If you do not submit to a stion(s) or provide the report(s) to the licensing authority, your be denied.				
2.	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.	•		_	nosed with, or treated for, pedophilia, exhibitionism, voyeurism or				
4.	Are yo	u currently	engaged	d in the illegal use of controlled substances?				
	"Curre	ently" mea	ns within	the past two years.				
	_			<b>substances</b> is the use of controlled substances (e.g., heroin, cocaine) en according to the directions of a licensed health care practitioner.				
	Note:	certified o	copies of	s" to any of the remaining questions, provide an explanation and f all judgments, decisions, orders, agreements and surrenders. The criminal background checks on all applicants.				
5.				icted, entered a plea of guilty, no contest, or a similar plea, or had deferred or suspended as an adult or juvenile in any state or jurisdiction? .				
	Note:	documen	ts relate	yes" to question 5, you must send certified copies of all court do to your criminal history with your application. If you do not ments, your application is incomplete and will not be considered.				
				granted certificate(s) of restoration of opportunity, please provide a each certificate.				
		may not a	utomationistory m	blic, the department considers criminal history. A criminal history cally bar you from obtaining a credential. However, failure to report nay result in extra cost to you and the application may be delayed				

DOH 670-107 June 2020 Page 2 of 5

2	Personal Data Quest	ions (Co	nt.)		Yes	No
6.	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?					
7.	Have you ever been found in any pro- regulating the practice of a health can provide copies of all judgments, decis	re profession	n? If "yes", pl	•		
8.	Have you ever had any license, certification profession denied, revoked, suspend	•		er privilege to practice a health care te, federal, or foreign authority?		
9.	Have you ever surrendered a creden avoid action by a state, federal, or for			mber 8, in connection with or to		
10.	Have you ever been named in any ci negligence, or malpractice in connec		•	vil judgment for incompetence, health care profession?		
11.	Have you ever been disqualified from of Social and Health Services (DSHS			persons by the Department		
3.	Education					
	( ) (	•	•	of the degree. Request your transcripts ool send <b>directly</b> to the Department of F		
	Graduate School	From (mm/yyyy)	To (mm/yyyy)	Degree and Major		

DOH 670-107 June 2020 Page 3 of 5

4. Other License, Certification, or Registration							
List all sta	ites, including Washington, where c	redentials are	or were held.				
State/	License/Certification/Registration Type		tification/Registration		Method Licensed		
Jurisdiction	License/Geruneauor//registration/Type	Year Issued	Number	Exam	Endorse.	Grandparented	
5. Dec	claration Working Towa	rd Licen	sure				
I declare	that I am working toward licensure	as a Social W	orker	A 1:		Dete	
racolare	I declare that I am working toward licensure as a Social Worker.  Applicant's Initials Date						

DOH 670-107 June 2020 Page 4 of 5

6. Applicant's Attestation				
I,, declare under penalty of perjury under the laws of the state of (Name of Applicant)				
Washington that the following is true and correct:				
I am the person described and identified in this application.				
<ul> <li>I have read RCW <u>18.130.170</u> and RCW <u>18.130.180</u> of the Uniform Disciplinary Act.</li> </ul>				
<ul> <li>I have answered all questions truthfully and completely.</li> </ul>				
<ul> <li>The documentation provided in support of my application is accurate to the best of my knowledge.</li> </ul>				
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 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)				

DOH 670-107 June 2020 Page 5 of 5





# **Out-of-State Credential Verification**

#### To Applicant:

Please complete this side of this 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. The regulatory agency will complete page two.

Name: Last	First		N	Middle
Mailing Address				
City			State	Zip Code
Phone (enter 10 digit #)		Cell (enter	r 10 digit	t #)
Email address				
Any other names used:				
Type of license(s) you hold or have	held in other	state(s):		
Washington State healthcare creder	ntial type you	ı are applyiı	ng for:	
Washington State healthcare creder	ntial number	(if available	e): Da	te Issued

Have the licensing agency complete page two and return this form to the address listed above. If you have any questions, please call 360-236-4700.

This form may be duplicated.

DOH 670-108 June 2020 Page 1 of 2

### (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, and title)				
Applicant was credentialed by:	Date:	Score:		
☐ Written Examination				
Name of examination:				
Other Examination	Date:	Score:		
Name of examination:				
Is credential current:	No Expiration Date	<b>:</b> :		
Is this individual considered to If "no," please attach explanation		our state?		
Has this credential ever been denied?  Suspended?  Revoked?  Surrendered?  Yes No  Surrendered?  Yes No  Reinstated?  Yes No				
If "yes," please provide a copy	of the final order or othe	r 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				
Signature:				
Title:				
	Date:			

DOH 670-108 June 2020 Page 2 of 2



# **Approved Supervisor Verification**

#### To the Supervisor:

Please review <u>WAC 246-809-334</u>. To supervise a licensed social worker advanced associate or social worker independent clinical associate, you must hold a license without restrictions that has been in good standing for at least two years.

You must not be a blood or legal relative or cohabitant of the licensed associate, licensed associate's peer, or someone who has acted as the licensed associate's therapist within the past two years.

Prior to the commencement of any supervision you must provide the licensed associate a declaration, stating that you have met the requirements of **WAC 246-809-334** and you qualify as an approved supervisor.

As an approved supervisor, I attest I have completed the following:

- A minimum of fifteen clock hours of training in clinical supervision obtained through:
  - Supervision course; or
  - Continuing education credits on supervision; or
  - Supervision of supervision; or
  - Or any combination of these; and
- Twenty-five hours of experience in supervision of clinical practice; or

I attest I will gain thorough knowledge of the supervisee's practice activities including:

- Practice setting
- Record keeping
- Financial management
- Ethics of clinical practice
- A backup plan for coverage

	on of Supervision—must be completed be not supervision in accordance	y supervisor and provided to licensed associate prior with <b>WAC 246-809-334</b> .
Ι,	, a licensed	in the State of
	(Name of Supervisor)	
	with license #	
attests to	that I (Name of Licensed Associate)	have read and met all the requirements in connection
with WAC	246-809-334	
Signature	of Supervisor	Date





#### **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

Licensed Social Worker Laws, RCW 18.225

<u>Licensed Social Worker Rules, WAC 246-809</u>

**Standards of Professional Conduct, WAC 246-16** 

#### **Online**

Social Worker Program, Web Page

Get important information about your credential type by subscribing to email alerts.