



## **Ocularist 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  
PO Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Ocularist Credentialing  
PO Box 47877  
Olympia, WA 98504-7877

### **Contact us:**

360-236-4700

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## 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 License Reissuance Fee.**  
**All fees are 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 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 one.
  - 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.** 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.

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## Ocularist Expired 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 if different from above address of record

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 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 four hours of education in the prevention, transmission and treatment of AIDS, which included 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 Applicable)

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. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of  
(Print applicant name clearly)

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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## **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](#)

[Ocularist Laws, RCW 18.55](#)

[Ocularist Rules, WAC 246-849](#)

### **Online**

[AIDS Training Resources, Reference Page](#)

[Ocularist Program, Web Page](#)