



Agency Affiliated Counselor Expired Credential Activation Application

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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:

Agency Affiliated Counselor 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 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 Certification 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.

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 on your certification. 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. Previous Credentialing.** List **all** licenses you have held since last being licensed in Washington State. List in chronological order, most current first. Include your last active licensed in Washington State. If you need more space, attach a sheet of paper.

- 3. Professional Experience.** In chronological order, list all your professional work experience since your Washington State credential expired. If you need more space, attach a sheet of paper.
- 4. AIDS Education and Training Attestation.** Required by [WAC 246-12-040](#).
- 5. Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- 6. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

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Agency Affiliated Counselor Expired Credential Activation Application

Please type or print clearly in ink. 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 (If you do not have a social security number, see instructions)

Male
 Female

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

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

Address

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

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	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):

For Office Use Only

Credential # _____ Issue Date _____

2. Previous Credentialing

List **all** licenses you have held since last being licensed in Washington State. List in date order, most current first. Include your last active licensed in Washington State. If you need more space, attach a sheet of paper.

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently in force	
		Type	Number	Yr Issued		No	Yes

3. Professional Experience

In date order, list all your professional work experience since your Washington State credential expired. If you need more space, attach a sheet of paper.

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. 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

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	Date

6. 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)

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Washington State Department of

Health

Agency Affiliated Counselor Credentialing

P.O. 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 credentialed. Instruct them to return the form directly to the address listed below. Make a copy of this form if you are or have been credentialed in more than one state and/or jurisdiction. Credentialing agencies normally charge a fee to verify a credential, please check in advance to help expedite this process.

Name:	Last	First	Middle
Mailing Address			
City	State	Zip Code	
Any other names used:			
Credential Number	Date Issued		

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

Please call 360.236.4700 if you have questions regarding this form.



RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.....	<u>RCW 18.130</u>
Administrative Procedure Act	<u>RCW 34.05</u>
Administrative procedures and requirements	<u>WAC 246-12</u>
Agency Affiliated Counselor, RCW	<u>RCW 18.19</u>
Agency Affiliated Counselor, WAC	<u>WAC 246-810</u>

OnLine

AIDS Training Resources	<u>Reference Page</u>
Agency Affiliated Counselor Program.....	<u>Web Page</u>

ListServ

To receive emails regarding important agency affiliated counselor professional Information, please join our interested parties list at: [Listserv](#)