



Certified Adviser Expired Credential Activation Application

Contents:

1. 670-141 Contents List/SSN Information/Mailing Information 1 page
2. 670-142 Application Instructions Checklist 2 pages
3. 670-143 Certified Adviser Expired Credential Activation Application 3 pages
4. 670-123 Out-of-State Credential Verification Form 2 pages
5. 670-124 Approved Supervisor Certified Adviser 2 pages
6. RCW/WAC and Online Web Site 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, 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:

Certified Adviser 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 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.

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. 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. 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](#).
- 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.

2. Other License, Certification, or Registration

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. Attach additional pages if you need more space.

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

3. Experience

In date order, list all your professional work experience since your Washington State credential expired. Attach additional pages if you need more space.

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. Continuing Education/Continuing Competency Attestation (if applicable)

I certify that I have met all continuing education and continuing competency requirements for the past two years. I am enclosing documentation on all classes attended/claimed.

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 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

Certified Adviser 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 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.



Certified Adviser Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Approved Supervisor Certified Adviser

To the Supervisor:

Please review [WAC 246-810-025](#) and [WAC 246-810-026](#). To act as a supervisor for a certified adviser, you must meet the following:

- Have an active credential in a counseling-related field for a minimum of five (5) years.
- The credential or credentials must be in good standing while serving as supervisor.

You must not be a blood or legal relative or cohabitant of the credential holder, or someone who has acted as the credential holder's counselor within the past two years. You must not have a reciprocal supervisory arrangement with another credential holder.

Prior to the commencement of any supervision, you must provide the certified adviser with a declaration of supervision.

As an approved supervisor, I attest that I have completed the following education and training in:

- Supervision or management of individuals who provide counseling or mental health services
- Risk assessment
- Screening using the global assessment of functioning scale
- Professional ethics
- Washington State law

A written agreement between the certified adviser and the supervisor is required. The agreement must be reviewed and renewed at least every two years. At a minimum, the agreement addresses the agreement duration, expectations of both parties, frequency and modalities of supervision, recordkeeping, financial arrangements, client confidentiality, and potential conflict of interest. [WAC 246-810-025](#).

Approved Supervisor Certified Adviser

Declaration of Supervision—must be completed by supervisor and provided to certified adviser prior to the commencement of supervision as set in [WAC 246-810-025](#).

I, _____
Name of Supervisor (print)

a credentialed _____

in the state of Washington with credential number _____

attests to _____ that I have read and met all
Name of Certified Adviser

the requirements in accordance with [WAC 246-810-026](#).

Signature of Supervisor

Date



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>
Certified Adviser, RCW	<u>RCW 18.19</u>
Certified Adviser, 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](#)