



Limited Physician and Surgeons Application Packet

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These are the standard forms you should find within this application packet. Any forms may be copied as needed. There are additional requirements for which there are no forms available; please read the instructions carefully in order to understand all that is required in order to be issued a license.

Important Social Security Number Information:

Social Security Number: 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 complete the [Social Security Number Notification](#).

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 only your application with your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send additional documents to:

Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866

Contact us:

A-L 360.236.2765
M-Z 360.236.2767

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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 typed or printed clearly. It is your responsibility to submit the correct forms required.

Application Fee. (This fee is 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 complete the [Social Security Number Notification](#) if you do not have one.

Legal Name: List your full name.

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.

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

Email: Enter your email address, if applicable.

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](#).

Institution or Training Program Information (Required Information)

Note: You must provide this information to become licensed.

Institution/Program Name: List the name of the institution or training program.

Institution/Program Name: List the name of the institution or training program address. Be sure to include the city, state, zip code, and county.

Physicians with a limited license may **NOT** change their institution address. Only the program may submit evidence of a program address change.

Medical Specialty

List medical school, year of graduation, and medical specialty.

#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 question. If you do not provide this, your application is incomplete and it will not be considered.

- 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.
- “Another jurisdiction” means any other country, state, federal territory, or military authority.

Step #3: Education and Experience:

Provide a chronological listing of your education preparation and post-graduate training from receipt of your degree from medical school to the time of application. This must include month and year, and beginning and ending dates, whether part of medical practice or not. All time breaks of 30 days or more must be accounted for. If you need more space, attach a piece of paper.

Step #4: Professional Experience:

List in chronological order any professional experiences you have had since medical school. A Curriculum Vitae or resume will **NOT** be accepted in lieu of completing this section of the application. If you need more space, attach a piece of paper.

Step #5: Hospital Privileges verification: Excluding post-graduate training hospital privileges:

Do not list any post-graduate training hospital privileges. If you had independent hospital privileges outside of a training program, please request all hospital privileges granted in the past five years verified and sent directly to this department. Forms provided.

Step #6: Licenses in Other States:

List in chronological order all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. If you need more space, attach a piece of paper.

Step #7: AIDS Education and Training Attestation:

AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training, required by [WAC 246-12-260](#) course content can be found at [WAC 246-12-270](#).

Step #8: Applicant’s Attestation:

You must sign and date this for us to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Step #9: Applicant’s Photograph:

Attach a current photograph in the box provided or attach to the application. Indicate the date the photograph was taken. Sign in ink across the bottom of the photo. The photograph must be a clear, close up, with a front view of applicant.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at <http://www.doh.wa.gov/hsqa/professions/military/> and include supporting documentation with your application.

Additional Information and Instructions

Limited Licenses Categories with specific requirements

Resident Physician Limited License:

- a. Includes interns and medical residents and fellows.
- b. The program must submit a residency certification form stating the beginning date of the program. The document must be original and submitted directly to this office by the program.

Fellowship or Teaching/Research Limited License

- a. A letter of nomination from the dean of the medical school at the University of Washington or chief executive of hospital or other appropriate health care facility licensed in the state of Washington. The letter must state the program start date.
- b. License verification from state or country of origin—state license verification must be original and received direct from licensing entity; licenses from country of origin may be a notarized copy of original license documents. A fellowship license has a limit of two years total.

Institutions or County-City Health Department Limited License:

- a. Original letter verifying employment received directly from official department. The letter must state employment start date.
- b. License verification from state or country of origin—state license verification must be original and received direct from licensing entity. Licenses from country of origin may be a notarized copy of original license documents.

Note: A limited license is only for practicing medicine within the limitation of the specific training program or institution or county-city department.

All application documentation required:

Malpractice: (if applicable) All medical malpractice law suits you have been named in must be reported and should include the nature of the case, date and summary of care given on the professional liability form provided. The applicant must also include copies of the settlement or final disposition. If pending, indicate status.

Transcripts: All medical school transcripts must list the dates of attendance, subject completed, degree and date awarded and sent directly to this office. **Exception:** A letter of verification from the dean of medical school will be accepted for a limited license; however, a copy of the official transcripts must be submitted. (Form provided)

Foreign Transcripts: Foreign medical school transcripts must list the dates of attendance, subjects completed; degree and date awarded and be sent directly to this office. All documentation must be translated to English. All translations must be original documents with the appropriate signatures and seals.

FSMB Data Bank Clearance and the AMA Physician Profile (Only those who have completed prior training in the U.S.): The Federation of State Medical Boards data bank clearance and the American Medical Physician Program will be obtained electronically by Department staff. If staff is unable to obtain either report, the applicant is responsible to obtain the reports and pay the necessary fees.

Renewal

The initial limited license is issued from the date the program starts for 13 months. The renewal notices will be sent to your program address about 6 to 8 weeks in advance. It is your responsibility to ensure the renewal is processed on time.

- Renewal applications for resident physician limited licenses must be submitted with a residency certification renewal form. May be renewed annually.
- Renewal applications for teaching-research limited licenses must include a letter of nomination from the dean of the medical school or hospital executive. May be renewed annually.
- Renewal application for fellowship limited license must include a letter of nomination from the dean of the medical school or hospital executive. May only be renewed once. May only renew once. Maximum of 2 years.

Address changes. Physicians with a Limited License may not change their institution/training program address. Only the program may submit evidence of a program address change or submit a new Residency Certificate Renewal Form if changing programs.

Important Telephone Numbers

Applicants whose last names are between A—L 360.236.2765

Applicants whose last names are between M—Z 360.236.2767



Social Security Number Notification

I have provided a social security number for the following reason:

- I do not have a social security number, and when I applied for one, it was denied.
(Attach any correspondence received from the Social Security Administration.)
- I do not have a social security number, but I have an individual taxpayer identification number, which is _____ .
- I have a social security number, but decline to provide it.
- I am a foreign national with a student visa only and do not qualify for a social security number because of that visa status.
- I will be in the United States on a visa and cannot apply for a social security number until my visa has been approved and I have entered the United States.
- I do not have a social security number, and when I applied for one, it was denied.
- Other (Provide a detailed explanation)

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Printed Name

Signature

Place Signed

Date Signed

(This page intentionally left blank.)

Background
Check
Stamp
Here

Date
Stamp
Here

Revenue 0252140000

Limited Physician & Surgeons License Application

- Resident Physician
 Teaching/Research
 Institutional
 Fellowship (2 year limit)
 County/City Health Department

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

| | | | | | |
|-------------------------|--|------------------------------|----------------|--------|---------|
| Name | | <input type="checkbox"/> Mr. | First | Middle | Last |
| | | <input type="checkbox"/> Ms. | | | |
| Birth date (MM/DD/YYYY) | | | Place of Birth | | |
| | | | City | State | Country |
| Address | | | | City | |
| State | | Zip | | County | |
| Phone # | | Fax # | | Cell # | |
| Email Address: | | | | | |

Have you ever been known under any other name(s)? If yes, list name(s): _____

Will documents be received in another name? If yes, list name(s): _____

Institution or Training Program Information (Required)

| | |
|-------------------------------------|--------|
| Institution/Program Name | |
| Institution/Program Mailing Address | |
| City | State |
| Zip | County |

Medical Specialty

| | |
|----------------|--------------------|
| Medical school | Year of Graduation |
|----------------|--------------------|

Medical Specialty

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable 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.
- 1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

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.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

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. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

- b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?
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?
- b. Diverted controlled substances or legend drugs?
- c. Violated any drug law?
- d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?

3. Medical Education and Experience

Provide a chronological listing of your educational preparation and post-graduate training. If you need more space, attach a piece of paper.

| Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.) | Diploma or degree obtained (Quote titles in original language and translate to English.) | Number of years attended | Dates granted | |
|---|--|--------------------------|-----------------|---------------|
| | | | Start (mm/yyyy) | End (mm/yyyy) |
| Medical education (list all medical schools attended) | | | | |
| | | | | |
| | | | | |
| Post graduate training (list all programs attended) | | | | |
| | | | | |
| | | | | |

4. Professional Experience

In chronological order list all professional experience received since graduation from medical school to the present. Exclude activities listed under other sections, identify any periods of time break of 30 days or more. If you need more space, attach a piece of paper.

| Name and location of institution | From (mm/dd/yyyy) | To (mm/dd/yyyy) | Nature of experience or specialty |
|----------------------------------|-------------------|-----------------|-----------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

5. Hospital Privileges (Excluding post-graduate training hospital privileges.)

Excluding post-graduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

| Name of hospital | Dates attended | |
|------------------|-----------------------|---------------------|
| | Start date mm/dd/yyyy | End date mm/dd/yyyy |
| | | |
| | | |
| | | |
| | | |
| | | |

6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. List in chronological order, starting with the most current.

| State | Date license issued | License Number | Basis of License | | Status of license | Any limitations on license |
|-------|---------------------|----------------|------------------|-------------|-------------------|--|
| | | | Exam date passed | Endorsement | | |
| | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes |

7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four (4) hours of education in the prevention, transmission, and treatment of AIDS. This education included 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.

| | |
|----------------------|------|
| Applicant's initials | Date |
| | |

8. Applicant's Photograph

Photo Here



Attach current photograph here. Indicate date taken and sign in ink across bottom of the photo.
NOTE: Photograph **must** be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view of applicant
5. Instant polaroid photographs **not** acceptable

Height _____

Weight _____

Hair color _____

Color of eyes _____

9. Applicant's Attestation

I, _____, declare under penalty of perjury under the
(Print applicant name clearly)

laws of 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 _____ (city, state)

By: _____
Signature of applicant

Applicant's Professional Liability Action History

Applicant's Name: _____ Today's Date: _____

Please submit a form for each past or current professional liability claim or lawsuit which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

1. Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit more pages of narrative if necessary.)

Date of occurrence: _____ Details: _____

2. Date suit or claim was filed: _____ Name and address of Insurance

3. Carrier that handled the claim: _____

4. Your status in the legal action (primary defendant, co-defendant, other): _____

5. Current status of suit or other action: _____

6. Date of settlement, judgment, or dismissal: _____

7. If the case was settled out-of-court, or with a judgment, settlement amount paid on your behalf, please disclose amount.

(You must enclose a copy of final disposition of case—this includes dismissals.) \$ _____

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature

Date

(This page intentionally left blank.)

Request for Medical School Transcripts or Degree Confirmation

University Medical School _____

Address _____

I am applying for license to practice as a physician in the state of Washington. Please send a copy of my medical school transcripts or degree confirmation with the medical degree and date granted posted directly to the Washington State Medical Quality Assurance Commission at the address below. Thank you for your assistance.

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

I authorize release of my medical school transcripts to be sent to the Department of Health.

Signature _____ Date _____

*** If a transcript is not yet available, submit letter of degree confirmation.**

Applicant: Please complete the identifying information below to assist the registrar's office in processing your request.

Student name: _____ SSN: _____

Year of graduation: _____ Birth date: _____
dd/mm/yyyy

Contact Address: _____

Contact Phone Number _____

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Washington State Department of
Health
 Medical Quality Assurance Commission
 PO Box 47866
 Olympia, WA 98504-7866
 A-L 360.236.2765
 M-Z 360.236.2767

LMT

To: Post Graduate Training Program Director

Facility name _____

Address _____

RE: Verification/evaluation of training

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. **All questions must be answered.**

| | |
|--------------------------------|-------------------------|
| Applicant Name (Print or type) | Birth date (mm/dd/yyyy) |
|--------------------------------|-------------------------|

Signature of applicant _____

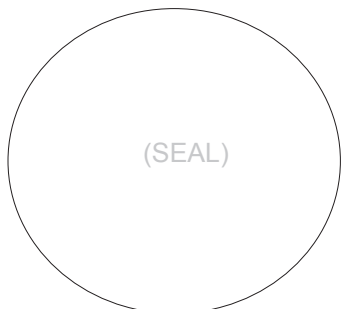
1. _____ is or was engaged in postgraduate training in our
 Applicant Name (Print or type)
 program _____
 from Beginning date (month & year) _____ to Ending date (month & year) _____
 in the field of _____

2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? Yes No
 If no, does this program qualify the applicant to become board certified? Yes No

3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? Yes No
 If yes, please explain _____

4. Did this applicant successfully complete this training program? Yes No
 in process OR expected date of completion _____

Return to address listed above.



Signature _____

Title _____
 (Please type or print)

Hospital _____

Address _____

Date _____ Telephone _____

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Washington State Department of
Health
 Medical Quality Assurance Commission
 PO Box 47866
 Olympia, WA 98504-7866
 A-L 360.236.2765
 M-Z 360.236.2767

LMT

To: State Medical Licensing Board

Name of State Medical Board _____

Address _____

RE: Verification of license/registration as a physician

I am applying for a license to practice medicine as a physician and surgeon in the state of Washington and before my application can be reviewed, a verification of my license status in your state is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown above. **All questions must be answered.**

| | |
|--------------------------------|-------------------------|
| Applicant Name (Print or type) | Birth date (mm/dd/yyyy) |
|--------------------------------|-------------------------|

Signature of applicant _____

This is to verify that _____ was issued license
Applicant Name (Print or type)
 number _____ on _____
(mm/dd/yyyy)

1. Date license, registration, or certification expires _____
 2. Have any complaints been lodged against the license?..... Yes No
 3. Is there currently any investigation in process regarding the license? Yes No
 4. Has any disciplinary activity taken place regarding the license? Yes No
- If yes, please provide any information or documentation which may be released; i.e., charges and final disposition.

Return to address listed above.

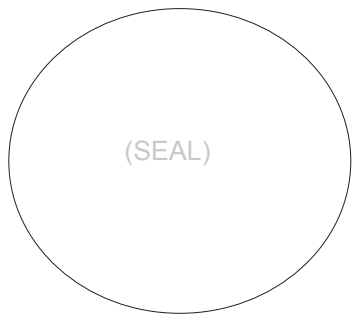
Signature _____

Title _____
(Please type or print)

State Medical Board _____

Address _____

Date _____ Telephone _____



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Washington State Department of

Health

Medical Quality Assurance Commission

PO Box 47866

Olympia, WA 98504-7866

A-L 360.236.2765

M-Z 360.236.2767

LMT

To: Hospital Administration (Excluding post graduate training hospital privileges)

Hospital Name _____

Address _____

RE: Verification and evaluation of privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown above at your earlie. **All questions must be answered.**

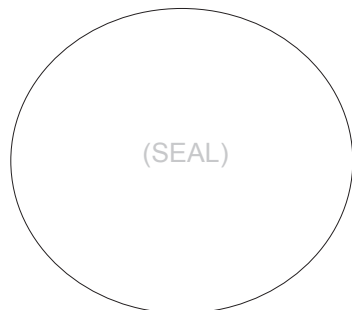
Applicant Name (Print or type)

Birth date (mm/dd/yyyy)

Signature of applicant

- _____ has/had admitting or specialty privileges at this hospital from _____ (mm/yyyy) to _____ (mm/yyyy).
- Have those privileges ever been restricted, suspended or revoked by the medical staff or administration? Yes No If yes, please explain _____
- Has the applicant every been asked to resign? Yes No If yes, please explain _____
- Did the applicant ever resign in lieu of or to avoid adverse action? Yes No
- Has a report concerning the applicant ever been sent to the National Practitioner Data Bank or the Health Care Integrity and Protection Data Bank by this hospital? Yes No

Return to address listed above.



Signature _____

Title _____
(Please type or print)

Hospital _____

Address _____

Date _____ Telephone _____

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Medical Quality Assurance Commission
Resident Physician Limited License

This certifies the appointment of the following individual who is being recommended for a limited license in Washington State.

Name of Resident Physician* : _____

Name of training program/specialty: _____

Name of sponsoring institution: _____

Beginning date _____
mm/dd/yyyy

(Signature) Director of Program

Is this an ACGME Program? Yes No

* Resident physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.055 and is serving a period of post graduate clinical medical training sponsored by a college or university in this state or by a hospital accredited by this state. The term shall include individuals designated as intern or medical fellow.

Note: The issuance of a limited license does not allow the individual to engage in the practice of medicine outside the supervision of the post-graduate clinical medical training program.

Return to:

Medical Quality Assurance Commission
P O Box 47866 Olympia, WA 98504-7866

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Health Professions Reference Numbers and Links

RCW/WAC and Links

**Uniform Disciplinary Act,
UDA RCW 18.130** <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130>

**Administrative Procedure Act,
APA RCW 34.05** <http://apps.leg.wa.gov/RCW/default.aspx?cite=34.05>

**Administrative procedures and requirements,
WAC 246-12** <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-12>

Physician RCW 18.71 <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.71>

Physician WAC 246-919 <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-919>

Online

**Medical Quality Assurance
Commission**..... <https://www.doh.wa.gov/hsqa/MQAC/default.htm>