

## Health Care Assistant Delegator Form

Health Care Assistant's Name (Print) \_\_\_\_\_

Health Care Assistant's Signature \_\_\_\_\_

Health Care Assistant's Certification Number \_\_\_\_\_

I certify the above individual will only perform the duties and administer medications or diagnostic agents for which he/she has been certified and approved by the Department of Health. As the delegator, I understand that I am responsible for appropriate supervision. The delegator must be an **M.D., D.O., D.P.M., P.A., A.R.N.P., or N.D.**

Delegator's Name (Print) \_\_\_\_\_

Delegator's Signature \_\_\_\_\_

Delegator's License Number \_\_\_\_\_

Facility Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Facility Location Address \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

### Notice

Any change of the medication list must be reported to the Department of Health within 30 days following the change.

New application for certification is necessary if there is a change in category authorization or health care facility. No certification made by one health care facility or health care practitioner is transferable to another health care facility or health care practitioner as set in RCW 18.135.140.

Please contact a customer service representative at 360.236.4700 for certification application information. Forms and information can also be located at our web site:

[http://www.doh.wa.gov/hsqa/professions/Health\\_Care/forms.htm](http://www.doh.wa.gov/hsqa/professions/Health_Care/forms.htm)