



Washington State Department of

Health

Health Care Assistant Program  
P.O. Box 47877  
Olympia, WA 98504-7877  
360.236.4700

## Health Care Assistant Certification 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  
Health Care Assistant Program  
P.O. Box 1099  
Olympia, WA 98507-1099

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

Customer Service Center  
P.O. Box 47877  
Olympia, WA 98504-7877  
360.236.4700

#### Contact us:

360.236.4700

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## **Health Care Assistant Certification Education Requirements for Categories A through F**

Washington Administrative Code, chapter 246-826, specifically, [WAC 246-826-130](#) through [WAC 246-826-180](#) identify categories A through F. Each category identifies the education, work experience and training required for the specific category.

The Department of Health requires an **official** transcript.

**Note:** If the applicant's transcripts do not clearly identify that he/she has taken all of the required courses, please provide course description(s) identifying which classes in the applicant's transcripts covered those subjects, or the application will not be processed.

### **WAC 246-826-130 Category A minimum requirements.**

Category A, to perform venous and capillary invasive procedures for blood withdrawal; administration of approved drugs restricted to topical, rectal, otic, ophthalmic, or inhaled routes.

**Education:** High school education or equivalent. No additional education is required.

### **WAC 246-826-140 Category B minimum requirements.**

Category B, to perform arterial invasive procedures for blood withdrawal; administration of approved drugs restricted to topical, rectal, otic, ophthalmic, or inhaled routes.

**Education:** Minimum high school education or equivalent with additional education to include but not be limited to anatomy, physiology, concepts of asepsis, and microbiology.

### **WAC 246-826-150 Category C minimum requirements.**

Category C, to perform intradermal (including skin tests), subcutaneous, and intramuscular injections for diagnostic agents; administration of approved drugs restricted to topical, rectal, oral, otic, ophthalmic, or inhaled routes.

**Education:** One academic year of formal education at the post-secondary level. Education shall include, but not be limited to, anatomy, physiology, basic pharmacology, concepts of asepsis, and microbiology.

### **WAC 246-826-160 Category D minimum requirements.**

Category D, to perform intravenous injections for diagnostic agents; administration of approved drugs restricted to topical, rectal, otic, ophthalmic, or inhaled routes.

**Education:** Two academic years of formal education at the post-secondary level. Education shall include, but not be limited to, anatomy, physiology, basic pharmacology, mathematics, chemistry, concepts of asepsis, and microbiology.

### **WAC 246-826-170 Category E minimum requirements.**

Category E, to perform intradermal (including skin tests), subcutaneous, and intramuscular injections for therapeutic agents; administration of approved drugs restricted to topical, rectal, oral, otic, ophthalmic, or inhaled routes.

**Education:** One academic year of formal education at the post-secondary level. Education shall include, but not be limited to, anatomy, physiology, pharmacological principles and medication administration, mathematics, concepts of asepsis, and microbiology.

**WAC 246-826-180 Category F minimum requirements.**

Category F, to perform intravenous injections for therapeutic agents; administration of approved drugs restricted to topical, rectal, otic, ophthalmic, or inhaled routes.

**Education:** Two academic years of formal education at the post-secondary level. Education shall include, but not be limited to, anatomy, physiology, pharmacological principles and medication administration, mathematics, chemistry, concepts of asepsis, and microbiology.

# Health Care Assistant Certification Education Requirement

## Category G Hemodialysis

Washington Administrative Code, chapter [246-826](#), specifically, [WAC 246-826-301](#), [WAC 246-826-302](#), and [WAC 246-826-303](#) identify category G, minimum requirements to perform hemodialysis, minimum training standards for mandatory hemodialysis technician training programs, and minimum standards of practice and core competencies of hemodialysis technicians.

The Department of Health requires verification from the Preceptor that the applicant:

- completed six to eight weeks of training in both didactic and supervised clinical instruction, as required by [WAC 246-826-302](#).
- meets the minimum standards of practice and core competencies of hemodialysis technicians as required by [WAC 246-826-303](#).

[WAC 246-826-301](#) Hemodialysis technician, category G minimum requirements to perform hemodialysis.

[WAC 246-826-302](#) Minimum training standards for mandatory hemodialysis technician training programs.

[WAC 246-826-303](#) Minimum standards of practice and core competencies of hemodialysis technicians.

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## General Instruction 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.

**Categories:** Please indicate categories you wish to apply for. See [Education Requirements](#) for definitions of categories.

**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.

**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 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 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 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](#).

**Facility/Delegator:** The delegator must be a medical doctor (MD), osteopathic doctor (DO), podiatric doctor (DPM), physician assistants (PA), advanced registered nurse practitioner with prescriptive authority (ARNP) or naturopathic doctor (ND) licensed in Washington State. Delegator name, license number and expiration date must be listed.

**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 provide the documentation listed in the note after the questions. If you do not provide this, your application is incomplete and it will not be considered.

## General Instruction Checklist (continued)

- 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 obtain 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.

### 3: Training and Education

List in chronological order your training and education. If you need more space, attach a piece of paper. For categories B, C, D, E or F, we require official transcripts be sent directly from your school to the Department of Health.

### 4: Professional Experience

List in chronological order your professional work experience.

### 5: Previous Credentials

List all states, including Washington State, where credentials are or were held. Check method of credentialing: exam, endorsement, or grandfathered. Enter year issued and credential number. If you need more space, attach a piece of paper.

**Note: Many states charge a verification/certification processing fee. Please contact them first to prevent a delay.**

### 6: Preceptor Attestation for Hemodialysis Technician

The preceptor supervises, trains, or observes a student giving direct patient care in a dialysis facility. The preceptor must be a medical doctor (MD), osteopathic doctor (DO), advanced registered nurse practitioner with prescriptive authority (ARNP) or registered nurse (RN) licensed in Washington State. Preceptor name, license number and expiration date must be listed.

### 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 in [WAC 246-12-270](#). Submit evidence of completion of four (4) clock hours of AIDS education. The requirement of [WAC 246-809-080](#) will satisfy this requirement.

### 8: Delegator Attestation

The delegator must attest to the applicant's education, work experience, clinical training, and supervision.

### 9: Medication and Diagnostic Agent List

For categories A, B, C, D, E, F, and G, list medication and diagnostic agent names you will use for injections and the specific route.

### 10: Applicant Attestation and Signature

You must sign and date this for us to process the application. Read this very carefully.

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required. Please do not call to check on the status of an application. This will allow program staff time to prepare your file for credentialing. If your application is incomplete, you will be mailed a letter regarding the deficiencies.

The application is considered incomplete if requested information is left blank. Put N/A or place a line through a section instead of leaving it blank.

You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.



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 360.236.4700

Background  
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Date  
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**Application for Certification as a Health Care Assistant**

Categories (check all that apply) See [Education Requirements](#) for definitions of categories.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> A. Venous capillary blood draw and administration of approved drugs restricted to oral vaccines, topical, rectal, otic, ophthalmic or inhaled routes. | <input type="checkbox"/> D. Intravenous injections for diagnostic agents and administration of approved drugs restricted to oral vaccines, topical, rectal, otic, ophthalmic, or inhaled routes.                   | <input type="checkbox"/> F. Intravenous injections for therapeutic agents and administration of approved drugs restricted to oral vaccines, topical, rectal, otic, ophthalmic or inhaled routes. |
| <input type="checkbox"/> B. Arterial blood draw and administration of approved drugs restricted to oral vaccines, topical, rectal, otic, ophthalmic or inhaled routes.         | <input type="checkbox"/> E. Skin tests and injections for therapeutic agents and administration of approved drugs restricted to oral medication and vaccines, topical, rectal, otic, ophthalmic or inhaled routes. | <input type="checkbox"/> G. Hemodialysis and administration of approved drugs restricted to oral vaccines, topical, rectal, otic, ophthalmic or inhaled routes.                                  |
| <input type="checkbox"/> C. Skin tests and injections for diagnostic agents and administration of approved drugs restricted to oral medication and                             |  |  |

**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): \_\_\_\_\_

**Facility/Delegator Information**

Facility Name	
Facility Mailing Address	
City	State
Zip	County
Delegator is (Check One) <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> PA <input type="checkbox"/> ARNP/PR Authority <input type="checkbox"/> ND	
Delegator Name	
Delegator License Number	License Expiration Date

**For Office Use Only**

Issuance Date \_\_\_\_\_ Credential# \_\_\_\_\_

**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, mental retardation, 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? .....

## 3. Training and Education

List in chronological order your training and education. If you need more space, attach a piece of paper.

Full Name, City and State/Schools Attended	Degree Earned	Attendance	
		Entrance Date	Ending Date

#### 4. Professional Experience

List in chronological order your work experience. If you need more space, attach a piece of paper.

Name and Location of Institution	From (MO/DAY/YR)	To (MO/DAY/YR)	Nature of Experience or Speciality

#### 5. Previous Credentials

List all states where credentials are or were held, including Washington State.

State	License/Certification/Registration Type	License/Certification/Registration		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grand Fathered

#### 6. Preceptor Attestation for Hemodialysis Technician—Category G Only

The hemodialysis technician, category G assistant shall receive training, evaluation(s), and assessment of knowledge skills to determine minimum level competency.

I, \_\_\_\_\_  
Preceptor Name—Type or Print  
(Who supervises, trains, or observes student providing direct patient care in a dialysis facility or center)

verify that \_\_\_\_\_  
Hemodialysis Technician—Type or Print

completed six to eight weeks of training in both didactic and supervised clinical instruction, as required by [WAC 246-826-302](#).

\_\_\_\_\_  
Signature of Preceptor \_\_\_\_\_  
Date

\_\_\_\_\_  
Preceptor License # \_\_\_\_\_  
Expiration Date

## 7. Aids Education and Training Attestation

- School curriculum  
 Employer/Other

I certify I have completed the minimum of seven 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.

Applicant's Initials	Date

## 8. Delegation of Procedures

I, \_\_\_\_\_,  
Delegator Name—Type or Print  
(Must be an MD, DO, DPM, PA, ARNP/PR authority, or ND)

verify that \_\_\_\_\_  
Health Care Assistant Name—Type or Print

may be delegated the authority to perform procedures applicable to the categories indicated. I attest that documentation of specific medications/diagnostic agents and routes of administration are authorized for this individual. Any alteration to the medication list will be provided to the Department of Health under my and the health care assistant's signatures within 30 days of the change.

I certify the health care assistant has met the required educational, clinical training, instruction, and work experience applicable for the categories indicated.

I certify appropriate supervision will be provided to the health care assistant in carrying out the procedures delegated.

Original Signature of Delegator \_\_\_\_\_ Date \_\_\_\_\_

**9. Medication and Diagnostic Agent List—Categories A, B, C, D, E, F, and G only**

Any changes of the medication list must be reported to the Department of Health within **30** days following the change. Additional medication/diagnostic agents may be listed on additional pages.

**Note: Oral medications can only be administered by categories C and E.**

Medications/Diagnostic Agents to be Administered Include	VIA (Route)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
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30	

I attest this health care assistant has demonstrated initial competency to administer the drugs listed above.

\_\_\_\_\_  
Delegator Name (Type or Print)

\_\_\_\_\_  
Health Care Assistant Name (Type or Print)

\_\_\_\_\_  
Original Signature of Delegator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Original Signature of Health Care Assistant

\_\_\_\_\_  
Date

WAC 246-826-100 remains in effect regarding the administration of vaccines by a health care assistant:  
<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-826-100>.

WAC 246-926-200 remains in effect regarding drug injections which may be administered by health care assistants categories C, D, E or F:  
<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-826-200>.

Effective July 26, 2009, new legislation expands the scope of practice of health care assistants regarding the administration of drugs:

Per RCW 18.135 New Section:

The administration of drugs by a health care assistant is restricted to oral, topical, rectal, otic, ophthalmic, or inhaled routes administered pursuant to a written order of a supervising health care practitioner. The drugs authorized for administration under this section are limited to the following:

Over-the-counter drugs that may be administered to a patient while in the care of a health care practitioner are: Benadryl, acetaminophen, ibuprofen, aspirin, Neosporin, polysporin, normal saline, colace, kenalog, and hydrocortisone cream.

Nonover-the-counter unit dose legend drugs that may be administered to a patient while in the care of a health care practitioner are: Kenalog, hydrocortisone cream, raglan, compazine, zofran, bactroban, albuterol, xopenex, silvadene, gastrointestinal cocktail, fluoride, 1mx cream, emla, lat, optic eyes, oral contrast, and oxygen.

## 10. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the 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: \_\_\_\_\_  
Original Signature of Applicant

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Washington State Department of

Health

Health Care Assistant Program

P.O. Box 47877

Olympia, WA 98504-7877

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## Health Care Assistant Program 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:

Department of Health  
Health Care Assistant Program  
P.O. Box 47877  
Olympia, WA 98504-7877

If you have any questions, please call 360.236.4700.

**(To be Completed by the Regulatory Agency)**

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of credential holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by: <input type="checkbox"/> Written Examination	Date:	Score:
Name of examination:		
<input type="checkbox"/> Other Examination	Date:	Score:
Name of examination:		
Is credential current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration Date:	
Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "no", please attach explanation.		
Has this credential ever been denied?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suspended?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Revoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surrendered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reinstated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "yes", please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**(SEAL)**

## **RCW/WAC and Online Web Site Links**

### **RCW/WAC Links**

Uniform Disciplinary Act.....	<a href="#"><u>RCW 18.30</u></a>
Administrative Procedure Act .....	<a href="#"><u>RCW 34.05</u></a>
Health Care Assistant Law .....	<a href="#"><u>RCW 18.135</u></a>
Health Care Assistant Rules.....	<a href="#"><u>WAC 246-826</u></a>

### **On-line**

AIDS Training .....	<a href="#"><u>Reference Page</u></a>
Health Care Assistant Web Page.....	<a href="http://www.doh.wa.gov/hsqa/professions/Health_Care/default.htm"><u>http://www.doh.wa.gov/hsqa/professions/Health_Care/default.htm</u></a>

### **List-Serv**

To receive emails regarding important health care assistant information, please join our interested parties at.....	<a href="#"><u>List-Serv</u></a>
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