



Washington State Department of
Health
 Medical Quality Assurance Commission
 P.O. Box 47866
 Olympia, WA 98504-7866
 A-L 360.236.2766
 M-Z 360.236.2765

Physician and Surgeon Expired License Activation Application Packet (Less Than Three Years) Contents:

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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, contact the Customer Service Center at 360.236.2750 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 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:

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Application Instructions Checklist

When your application is received by the department, you will be sent a letter noting receipt and any documents needed to complete the process. This is the only notice you will receive while your application is pending. Please do not call to check on the status of an application until you have received your acknowledgement letter. This will permit program staff to prepare your file and re-activate your license at the earliest possible time.

To ensure that 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 Credential Reissuance Fee.**

All fees are non-refundable. These fees are located on the Medical Quality Assurance Program [fee page](#)

- Box #1 Demographic Information.**

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.2750 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 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 separate piece of paper.
- Box #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 separate piece of paper.
- Box #4 AIDS Education and Training Attestation.** Required by [WAC 246-12-040](#).
- Box #5 Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- Box #6 Continuing Education Attestation.** Required by [WAC 246-12-040](#).
- Box #7 Applicant's Attestation.** Required to be both signed and dated in order to process the application.

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Physician and Surgeon Expired License Activation Application

Please type or print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could result in a delay in processing your application. Make sure you have read and understand the instructions.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.) _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name	First	Middle	Last
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Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

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

Country

Phone ()	Fax ()	Cell ()
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Email address

Mailing address (if different from above)

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

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information 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

Issuance Date _____ License # _____

Validation Date _____ Received _____

2. Previous Credentialing

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently In Force	
		Type	Number	Year Issued		No	Yes

3. Professional Experience

Nature of experience of practice and location	start (mm/yyyy)	end (mm/yyyy)

4. AIDS Education and Training Attestation (Check Appropriate Box)

I certify I have completed the minimum of four (4) 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 (2) 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

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

6. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify that I have met all continuing education and competency requirements for the past two (2) years. I am enclosing documentation on all classes attended/claimed.

APPLICANT'S INITIALS

7. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)
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 _____ in _____ (city, state)

By: _____
Signature of applicant