



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 Assistant Medical Application Packet

Contents:

1.	656-135 .. Contents List/SSN Information/Mailing information	1 page
2.	656-137 .. Application Instructions Checklist.....	2 pages
3.	656-115 .. Additional Information and Instructions Out of Practice Over Two-years and Other Instructions	2 pages
4.	656-001 .. Physician Assistant License Application for Practice with MDs only	6 pages
5.	656-130 .. Physician Assistant Interim Permit Request.....	1 page
6.	656-128 .. Professional Liability Action History Form	1 page
7.	656-116 .. Request for Transcripts	1 page
8.	656-114 .. Training Verification/Evaluation	1 page
9.	656-113 .. License Verification	1 page
10.	656-111 .. Evaluation of Privileges Verification	1 page
11.	656-011 .. Mandatory Continuing Medical Education Information For Physician Assistants.....	1 page
12.	RCW/WAC Links, AIDS Courses, Online Web Sites,	1 page

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

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.

Step #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 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](#).

Step #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.

- #3: Training and Education:**
From the time of your physician assistant degree to the time of application list all educational experience or experiences in chronological order. This must include month and year and beginning and ending dates; whether part of a medical practice or not. All time breaks of 30 days or more must be accounted for.
- #4: Professional Experience:**
In chronological order, list all professional work experience since you completed your physician assistant program. If you need more space, attach a piece of paper.
- #5: Hospital Privilege Verification:** (Not for training privileges)
Applicants must have verification sent directly to this office from all hospitals where admitting or specialty privileges have been granted in the past five years. Verifications must be received directly from each hospital. (Form provided)
 - Verification for military hospital privileges may be obtained by the current duty station or, if no longer in active service, the Human Resource Command, 1 Reserve Way, St. Louis, MO 63132.
- #6 Licenses in Other States:**
List all previous and current licenses, registration and certification **of any** health care profession you have held starting with the most current. If you need more space, attach a piece of paper.
- #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](#).
- #8: 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.
- #9: 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.



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Additional Information and Instructions

Important Note for applicants who have not practiced clinical medicine for at least two years.

If an applicant has **not practiced clinical medicine for two or more years**, the Commission may require the applicant to do one or more of the following:

- Undergo a knowledge and skills assessment at The Center for Personalized Education for Physicians CPEP 303.750.7150 or www.cpepdoc.org).
- Undergo a knowledge and skills assessment at the University of California at San Diego School of Medicine, Physician Assessment and Clinical Education Program (PACE) 619.543.6770 or <http://www.paceprogram.ucsd.edu/>.
- Complete any other examination, supervision plan, monitoring or assessment the Commission deems appropriate.

Once the Commission requests an applicant to complete one of these requirements, the Commission will not permit the applicant to withdraw the application. If the applicant does not successfully comply with the Commission's request to complete one of the above items, the Commission may deny the application.

The Commission cannot refund application fees. [WAC 246-12-340](#).

This application is for medical school graduates only.

Important Information

Prior to applying for license, please read through carefully and consider all the following laws on applications:

- The following conduct, acts or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter.
- Fees submitted with applications for initial credentialing, examinations, renewal, and other fees associated with the licensing and regulation of the profession are non-refundable.
- An application for a license may not be withdrawn after the commission or the reviewing commission member determines that grounds exist for denial of the license or for the issuance of a conditional license.

After the application and fees have been received by the Department of Health, the applicant will be notified if any documents or data are missing. Applicants should allow a minimum of twelve to sixteen weeks for processing. Only complete applications will be considered for review. Routine applications require five days for processing. Non-routine applications require more time for processing. All information, documents, data, etc. provided to the department by the applicant will become a part of the file.

Transcripts:

Official transcripts must be sent directly to this office from the applicant's physician assistant program to this office listing the dates of attendance, subjects completed and date awarded.

- Program Verification:**
Verification of participation in an approved physician assistant program must be received directly from the program director's office. (Form provided)
- Reporting Medical Malpractice:**
Reporting of any medical malpractice history must be submitted on the Professional Liability Action History form. Malpractice information must include detailed information on the nature of the case, date and summary of care given. The applicant must also include copies of the settlement paid by you or on your behalf or judgment. If pending, indicate status. (Form provided)
- FSMB Profiles and NCCPA Certification:**
The department staff will obtain Federation of State Medical Boards (FSMB) data bank clearance report and the NCCPA Certification. However, if staff is unable to obtain the reports electronically, the applicant will be required to submit requests and pay any applicable fees.
- Interim Permit Form:**
Physician assistants who have not yet obtained certification by the NCCPA examination may request an Interim Permit. Applicant should submit the request along with an application. Once issued, this permit will be valid for only one year. (Form provided.)
- Practice Plan:**
Physician assistant shall not begin practice without the Commission's written approval of the practice plan of that working relationship. Practice plans are to be completed jointly by the physician and physician assistant. Physician assistant may not practice in any area of medicine or surgery that is beyond the sponsoring physician's own usual scope of expertise. (Form provided)
- Prescriptive Authority Form:**
Physician assistants holding an interim permit may not prescribe without the Commission's written approval of the Prescriptive Authority Request form. The prescriptive authority approved by the Commission is not in lieu of DEA licensure. Please contact the DEA directly at 206.553.5996. (Form provided.)



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Background
Check
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Date
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Here

Revenue 0252090000

Physician Assistant License Application

Check one box only: Certified Physician Assistant
 Physician Assistant/Intern Permit

1. Demographic Information

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

Male
 Female

Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

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

Country

Phone ()	Fax ()	Cell ()
------------------	----------------	-----------------

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

Physician Assistant Program	Year of graduation
-----------------------------	--------------------

NCCPA Certification Number	Date Issued
----------------------------	-------------

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?
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. Training and Education

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) 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 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 _____ at _____ (city, state)

By: _____
Signature of applicant



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Interim Permit Request

I hereby request a **one time only physician assistant interim permit**. I understand that the interim permit shall expire one year upon the issuance of a license. If, during that year the Commission receives verification from the NCCPA that have passed the examination, this permit will be converted to a full PA-C license.

Signature _____ Date _____

Print or type full name _____ Date of birth _____

Mailing address _____

City _____ State _____ Zip Code _____

General Information

A interim permit may be issued upon receipt of the following:

1. Completed application form.
 - a. Personal data questions 1-10 must ALL be negative, excluding #10 regarding malpractice.
2. Interim permit request form.
3. Application and fees paid.
4. Physician Assistant Program Transcript.
5. Physician Assistant Program Director Evaluation Form.
6. Verification from states that the applicant was or is licensed (if applicable).
7. Verification of hospital privileges granted in the last five years (if applicable)
8. A clear Federation of State Medical Boards (FSMB) data bank clearance report.

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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 additional pages of narrative if necessary.

Date of occurrence: _____ Details: _____

2. Date suit or claim was filed: _____

Name and address of insurance carrier that handled the claim: _____

3. Your status in the legal action (primary defendant, codefendant, other):

4. Current status of suit or other action: _____

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

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

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PA

Request for Transcripts

University _____

Address _____

I am applying for license to practice physician assistant in the state of Washington. Please send a copy of my transcripts 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
 360.236.4785

I authorize release of my transcripts directly to the Washington State Department of Health.

 Signature Date

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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To: Physician Assistant 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 (Print or type) _____ Birth date _____

Signature of applicant _____

1. I _____

was engaged in postgraduate training in our program from _____ to _____ in the field of
(mm/yyyy) (mm/yyyy)

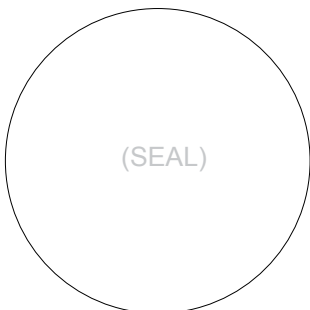
2. At the time this individual completed the physician assistant program, was the program accredited through the Committee on Allied Health Education and Accreditation (CAHEA), the Commission on Accreditation? _____ of Allied Health Education Programs CAAHEP), or the Accreditation Review Committee on Education for the Physician Assistant (ARC-PA)? Yes No

If yes, what year was the initial accreditation granted? _____

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

If yes, please explain _____

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



Signature _____

Title _____

Address _____

Please type or print

Date _____

Telephone _____

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 M-Z 360.236.2765

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To: State Medical Licensing, Registration, or Certification

Medical Institution Name _____

Address _____

RE: Licensing, Registration or Certification Verification/evaluation

I am applying for a license to practice medicine as a physician assistant 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 below. **All questions must be answered.**

Applicant (print or type) _____ Birth date _____

Signature of applicant _____

This is verify that _____ was issued license number _____ on _____

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 this license? Yes No

If yes, please provide any information or documentation which may be released; i.e., charges and final disposition.

Return to:

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Signature _____

Title _____

Please type or print

Address _____

Date _____

Telephone _____

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TO: Hospital Administration (Not for Training Purposes.)

Medical institution Name _____

Address _____

RE: Verification and evaluation of privileges

I am applying for a license to practice as a physician assistant 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 below at your earliest convenience. **All questions must be answered.**

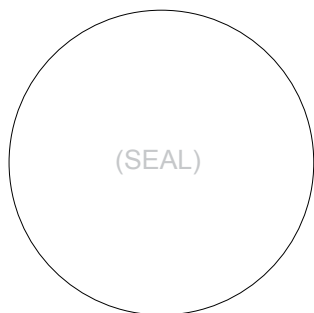
Applicant (print or type) _____ Birth date _____

Signature of applicant _____

1. _____ now has/has had admitting or speciality privileges at this hospital from _____ to _____ .
2. Have those privileges ever been placed on probation, restricted, suspended or revoked by the medical staff or administration? Yes No If yes, please explain _____
3. Has the applicant ever been asked to resign? Yes No If yes, please explain _____

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Signature _____

Print Name _____

Please type or print

Title _____

Medical Institution _____

Address _____

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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 Assistants RCW 18.17A.... <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.71A>

Physician Assistants WAC 246-918 . <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-918>

WAC 246-918-990 Physician assistant fees and renewal cycle. Licenses must be renewed every two years on the practitioner's birthday.

WAC 246-12-020 (3) How to obtain an initial credential. The initial credential will expire on the practitioner's birthday. Initial credentials issued within ninety days of the practitioner's birthday do not expire until the practitioner's next birthday.

WAC 246-12-310 Address changes. It is the responsibility of each practitioner to maintain his or her current address on file with the department. Requests for address changes must be made in writing. The mailing address on file with the department will be used for mailing of all official matters to the practitioner.

Continuing Education

Physician Assistants Continuing Education Rules,
WAC 246-918-180<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-918-180>

On-Line

Medical Quality Assurance
Commission.....<https://fortress.wa.gov/doh/hpqa1/hps5/Medical/default.htm>