



Washington State Department of
Health
 Board of Osteopathic Medicine and Surgery
 P.O. Box 47877
 Olympia, WA 98504-7877
 360.236.4700

Osteopathic Physician and Surgeon License Activation Application Packet (Over 3 years)

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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 360.236.4700 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
 PO Box 1099
 Olympia, WA 98507-1099

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

Osteopathic Program
 PO Box 47877
 Olympia, WA 98504-7877

Contact us:

360.236.4700

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Board of Osteopathic Medicine and Surgery
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Application Instructions Checklist

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 to prepare your file for reactivation.

To ensure 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. 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 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 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 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](#).
- #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 license in Washington State. If you need more space, attach a piece of paper.
- #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 piece of paper.
- #4 AIDS Education and Training Attestation.** Required by [WAC 246-12-040](#).
- #5 Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- #6 Continuing Education Attestation.** Required by [WAC 246-12-040](#).
- #7: Hospital Privileges:**
List hospitals and locations where privileges have been granted within the past five (5) years. If you need more space, attach a piece of paper.
- #8 Applicant’s Attestation.** Required to be both signed and dated in order to process the application. Read this very carefully.

Additional Documentation Required for Activation

- Professional Liability Action History.** Malpractice information pertaining to any civil suit or judgment in connection with the practice of a health care profession. Include the nature of the case, date and summary of the care given, and settlement amount. The applicant must provide a summary of each case. Include copies of the settlement or final disposition. If pending, indicate status. If the case is old, you can contact the county where it was filed to get the documentation. Please attach on a piece of paper.
- State License Verification.** Applicants must verify all osteopathic medical licenses that he or she holds, or has held, in any other state, territory or possession of the United States or Canadian province since the expiration date of your previous Washington State credential. Verification is required whether the license is active or inactive. This includes temporary and training licenses. Applicants should contact the state licensing authority for information regarding fees for verification of license. Form provided.
- Hospital Privileges.** Applicants must verify all hospitals where admitting or specialty privileges have been granted in the last five (5) years. Verification must be received directly from the hospital. All hospital privileges connected with military practice experiences may be verified by the current duty station. If no longer in active service, the appropriate agency of record or National Personnel Records Center, Military Personnel Records, 9700 Page Boulevard, St. Louis, MO 63132. **Form provided.**
- Federation of State Medical Boards Data Bank Clearance.** The Board requests verification of any disciplinary actions directly from the Federation.
- American Osteopathic Association Physician Profile.** The Board requests education and training profiles directly from the AOA.

The re-activation process requires we must get your previous credential file from the state records center. This takes about two (2) weeks. Pursuant to [WAC 246-853-025](#) a reactivation applicant may be required to take a special purpose examination. Once the abbreviated application is considered complete, it will be referred for review. All information, documents data, etc., provided to the department by the applicant is to be submitted in writing and will become part of the file. Telephone information will not be accepted in place of written documentation. The department may conduct additional investigation of irregular information contained in the file or documentation by contacting primary sources or other agencies as necessary to verify application information. Primary source documentation must be original. Faxed documents will not be accepted.



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Background
Check
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Date
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Revenue 0252070000

Osteopathic Physician and Surgeon 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.)

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 ()
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Email address

Mailing address (if different from above)

City	State	Zip	County
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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

License # _____ Issue Date _____
Validation Date _____ Received _____

2. Previous Credentialing (Include Previous Credentials in Washington State)

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

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS. This includes 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.

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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.

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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.

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7. Hospital Privileges

List hospitals and locations where privileges have been granted within the past five (5) years. If you need more space, attach a piece of paper.

Name of hospital and location	Attendance	
	From mm/yyyy	To mm/yyyy

8. 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)
mm/dd/yyyy

By: _____
Signature of applicant

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Hospital Investigative Letter

Name of applicant _____ Birthdate _____
Print mm/dd/yyyy

I have applied for a license to practice osteopathic medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my hospital privileges and return it directly to:

Board of Osteopathic Medicine and Surgery, PO Box 47877, Olympia, Washington 98504-7877
 360.236.4700

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Board of Osteopathic Medicine and Surgery.

Applicant Signature _____ Date _____

1. Does the applicant have, or has he/she ever had admitting or specialty privileges at your hospital?
 Yes No Beginning Date _____ Ending Date _____
2. Have the applicant's privileges ever been restricted, suspended or revoked by the medical staff or administration, or has he/she ever been asked to resign? Yes No
 If so, for what reason _____

3. Is there any information in your files that could call into question the applicant's ability to safely practice osteopathic medicine and surgery? Yes No
 If yes, please explain _____

Please attach any copies of information in your records that would provide further information.

Name _____ Title _____

Facility _____ Telephone Number _____

Address _____

Authorized Signature _____ Date _____

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State License Investigative Letter

Name of applicant _____ Birthdate _____
Print mm/dd/yyyy

I have applied for a license to practice osteopathic medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my hospital privileges and return it directly to:

Board of Osteopathic Medicine and Surgery, PO Box 47877, Olympia, Washington 98504-7877
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Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Board of Osteopathic Medicine and Surgery.

Applicant Signature _____ Date _____

To assist the Washington State Board in evaluating the above osteopathic physician's application, we would appreciate receiving the following information.

License Number _____ Date license was issued _____

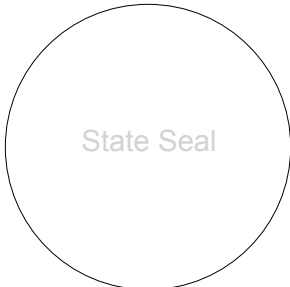
Status of License: Active Military Other
 Inactive Expired

Has the applicant's license ever been suspended or revoked? Yes No

Has any other disciplinary or corrective active been taken? Yes No

Has the licensee surrendered the license in lieu of disciplinary action? Yes No

If you have answered Yes to any of the questions above, attach supporting documentation pertaining to disciplinary orders or any other actions.



State Board _____

Address _____

Telephone Number _____

Authorized Signature _____

Date _____