



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 Application Packet

Contents:

1. 663-032.... Contents List/SSN Information/Mailing information 1 page
2. 663-063.... Application Instructions Checklist..... 2 pages
3. 663-035.... Additional Information 4 pages
4. 663-001.... Osteopathic Medicine and Surgery License Application 5 pages
5. 663-036.... Training Verification..... 1 page
6. 663-039.... Training Investigative Letter 1 page
7. 663-037.... Hospital Investigative Letter 1 page
8. 663-038.... State License Investigative Letter 1 page
9. RCW/WAC Links, AIDS Courses, Online Web Sites, 1 page

These are the standard forms you should find within this application packet. Any forms may be copied as needed. There are some requirements for which there are no forms available; please read the instructions carefully in order to understand all requirements to be issued a license.

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:

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

Contact us:

360.236.4700

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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 required forms required.

Application Fee. This fee is 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 license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the 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: 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: Osteopathic Medical Education and Post Graduate Training:**
Provide a chronological listing of your post-graduate training. If you need more space, attach a piece of paper. Verify all accredited post graduate training received in the United States. Verification must be completed by the program director with beginning and ending dates. It must be sent directly to this office.
- #4: Professional Experience:**
List in chronological order all professional experience and practice from date of graduation from professional college. If you need more space, attach a piece of paper.
- #5: Hospital Privileges:**
List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five years. If you need more space, attach a piece of paper.
- Verifications must be received directly from each hospital. This does not include post graduate training hospitals.
 - 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.
 - Locum Tenens: Hospital privileges of a 30-day or longer duration.
- #6: Previous Licenses in Other States:**
List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is 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 in [WAC 246-12-270](#).
- #7: Applicant's Attestation:**
You must sign and date this for us to process the application. Read this very carefully.
- #8: Applicant's Photograph:**
Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be clear, close up and a front view. Your application will not be processed without a current photograph.



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License Requirements

To qualify for a license to practice osteopathic medicine and surgery in the state of Washington you must have:

1. Graduated from a college or school of osteopathic medicine accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation.
2. Satisfactorily completed a nationally approved one-year internship program or the first year of a residency program approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations.
3. Completed an examination approved by the Osteopathic Medicine and Surgery Board. See: Examinations Accepted for Endorsement and State Examination.

General Instructions

- The application process is considered confidential. Information about a pending application will only be provided to the applicant, or a person identified in writing by the applicant.
- Applications and supporting documents should be complete at least 60 days before you anticipate beginning work in the state of Washington. After initial review, more documentation or information may be requested. More time may also be required to complete any investigation requested by the Board. Practice is not permitted prior to issuance of a license.
- Verification forms have been included in the packet for your convenience. You are not required to use those specific forms, but verifications must contain all of the information specified on the forms.
- All documents must be received from the originating source. Documents verifying your education, training, hospital privileges, or state licenses will not be accepted from you. Copies or faxed documents will not be accepted.

Documents Required

1. Official osteopathic school transcripts indicating osteopathic doctorate degree.
2. Verification of all accredited postgraduate training, including internships, residencies, and fellowships. The postgraduate training forms must be completed by the program director and include the beginning and ending dates of the training. Copies of evaluations, or a summary of the applicant's performance, may be included.
3. Verification letters from all hospitals where you have been granted privileges within the past five years.
4. Verification letters from all states where you have been issued a license, whether active or inactive. This includes training licenses.
5. Verification of a qualifying examination. See "Examinations Accepted for Endorsement and State Examination" for examinations accepted for license.

Temporary Permits

A valid license is required to practice osteopathic medicine and surgery in the state of Washington. A one-time temporary permit may be issued for ninety (90) days if you have a license in another state that has equivalent licensing standards to Washington's. You must have no disciplinary history in any state or any "Yes" answers to the Personal Data Questions. You must apply for a full license. The temporary permit is intended for you to be able to begin work while waiting for issuance of your full license.

Note: Verification of equivalency standards from the other state may take longer than it takes to complete the full license application process. Depending on how long it takes to get your documents listed below, you may not benefit by applying for the temporary license. Fees are nonrefundable.

Temporary Permit Requirements:

- Completed application, endorsement (NBOME only) and temporary permit application fees. You can check the [fee page](#) for current fees.
- Documentation from the other state where its licensing standards are equivalent to those of Washington.
- Verification of all state licenses, whether active or inactive, indicating you are not subject to disciplinary charges or that disciplinary action has not been taken against your license for unprofessional conduct or impairment.
- No "Yes" answers to any Personal Data Question, including #10 regarding malpractice suits.

Examinations Accepted for Endorsement Applications:

- Parts I, II, and III examination given by the National Board of Osteopathic Medical Examiners or Level 1, Level 2 CE and/or Level 2 PE, and Level 3 of the COMLEX.

Contact: National Board of Osteopathic Medical Examiners, Inc., 8765 W. Higgins Rd, Suite 200, Chicago, IL 60631-4101

Telephone 773.714.0622

Online: <http://www.nbome.org/>

Email: CandidateService@nbome.org

- FLEX examination taken prior to June 1985. Passed with a FLEX weighted average of at least 75 percent.
- FLEX I and FLEX II examinations with a minimum score of seventy-five (75) on each component.
- USMLE Steps 1, 2, and 3 with a minimum score as established by the testing agencies.

If your endorsement exam is the FLEX, FLEX I & II, or the USMLE exam, you will also be required to pass the Washington Osteopathic Principles and Practices examination with a seventy-five (75) percent average.

FLEX/USMLE scores: The Federations's Examination and Board Action and History Report (EBAHR) must be sent from:

The Federation of State Medical Boards, P.O. Box 619850, Dallas, TX 75261-9850

Telephone 817.868.4000

Online: <http://www.fsmb.org.transcripts.html>

- Other state examinations may be accepted if they include an osteopathic practices and principles section. The Board will determine if the other state's examination is equal to the Washington examination requirements. Examination scores must be certified by the state where the examination was taken.

State Examination

The USMLE (Step 1, 2, & 3) is the approved state examination after December 1993. Steps 1 and 2 are taken during osteopathic medical school. In addition to the USMLE exam, applicants must obtain a seventy-five (75) percent average on the Washington osteopathic principles and practices examination to complete the examination requirements.

USMLE, STEP 3 Eligibility

- Graduate of an accredited osteopathic medical school. Graduation must be confirmed by the Federation of State Medical Board (FSMB) Step 3 deadline date.
- The examination application, instructions, and deadline dates may be obtained online at: http://www.fsmb.org/m_usmlestep3.html.

Application for Limited License While in Postgraduate Training

A limited license is issued to practice osteopathic medicine and surgery while you are training in a postgraduate (internship, residency, or fellowship) program in Washington. The limited license does not authorize you to engage in practice outside the training program. The limited license permits practice only under supervision of a physician licensed in Washington under chapter 18.57 RCW or chapter 18.71 RCW.

Requirements:

- Completed application form - Check Limited License (Postgraduate Program). Limited license application fee. You can check the [fee page](#) for current fees.
- Official osteopathic school transcripts indicating osteopathic doctorate degree.
- Completion of the Limited License Postgraduate Training Verification form by the program director from your training program in Washington.
- Verification of other postgraduate training, hospital privileges, or state licenses as described in the Application and Documents to be Submitted section, if applicable.

Limited licenses are issued for one year from the beginning date of your postgraduate training and may be renewed annually until completion of the program.

Alternative Documents Accepted – Federation Credentials Verification Service (FCVS)

The Federation of State Medical Boards has a central repository for core physician documents. Core documents are defined as the basic documents that do not change, for example, transcripts, postgraduate training, and examination scores. The FCVS is operated on behalf of participating state medical boards but your participation is optional. At your request, those core documents will be provided to the designated state licensing board.

The Board will accept the core documents from FCVS. In addition to the core documents, you may need to submit other documents to complete the application file. You will still be required to provide hospital and state verifications and any other information specified in the instructions that apply to your application. The Board may make further inquiries or conduct an investigation related to information provided during the application process.

For information on participating in the FCVS or ordering core documents, contact 1.888.ASK.FCVS (275.3287), Online: <http://www.fsmb.org/fcvs.html>, or email fcvs@fsmb.org.

Other Background Information Checked by the Board for all Applicants

- AOA profile
- Federation of State Medical Board Data Bank Report
- National Practitioner Data Bank Report
- Washington State Criminal Background Report

The current address and telephone number of a health care provider governed under chapter [18.130 RCW](#) is not public information.



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Background
 Check
 Stamp
 Here

Date
 Stamp
 Here

Revenue 0252070000

Osteopathic Medicine and Surgery License Application

Application for (check one):

- Full License _____
 Temporary License (for a full license applicants)
 Limited License (Postgraduate Program) _____

Application for license is made by (check one):

- National Board Endorsement
 FLEX Endorsement/Washington Examination
 USMLE Endorsement/Washington Examination
 State Examination Endorsement

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): _____

Medical Specialty

Osteopathic school Year of graduation

Medical specialty

For Office Use Only

License # _____ Issue Date _____

Validation Date _____ Received _____

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. Osteopathic Medical Education and Post Graduate Training

Provide a chronological listing of your osteopathic educational preparation and post-graduate training. If you need more space, attach a piece of paper.

Schools attended Osteopathic medical education (list all osteopathic schools attended and location) Post graduate training (list all programs attended and location)	Years attended	Dates granted	
		Start dd/mm/yyyy	End dd/mm/yyyy

4. Professional Experience

In chronological order list all professional experience since completion of post-graduate training. Exclude activities listed under other sections. If you need more space, attach a piece of paper.

Name of practice or experience and location	From mm/yyyy	To mm/yyyy	Nature of experience or specialty

5. Hospital Privileges

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

Name of hospital and location (For locum tenens, enter only those of a 30-day or longer duration). See instructions in step 5 of the General Instructions Checklist, Hospital Privileges.	Dates attended	
	From mm/yyyy	To mm/yyyy

6. Previous License

List all licenses to practice osteopathic medicine in any states or US Territories.

State or territory	Certificate		Permanent or Temporary	License received		Currently in force
	Year	Number		Exam	Other	
						<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
						<input type="checkbox"/> No <input type="checkbox"/> Yes

7. Aids Education and Training Attestation

I certify that I have completed a 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. **AIDS training may include self study, direct patient care, Online courses, or formal training.**

Applicant's initials	Date
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8. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)
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)
mm/dd/yyyy

By: _____
Signature of applicant

9. 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 _____

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Training Appointment Verification

This is to certify that _____ has been accepted in
 Name of osteopathic* physician

a postgraduate training program in _____ at
 Type of residency program

_____ for the period beginning
 WA State training institution

_____ . The individual responsible for this resident's patient care
 Start date

activities will be _____
 Director of program (print name)

Program address _____

Signature _____

* A resident osteopathic physician means an individual who has graduated from an approved school of osteopathic medicine. The resident must be serving a period of postgraduate clinical training sponsored by a college or university in this state or by a hospital accredited in this state whose program is approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations. The term shall include individuals designated as intern, resident, or medical fellow.

Return Completed Form To:
 Board of Osteopathic Medicine and Surgery
 P.O. Box 47877
 Olympia, Washington 98504-7877

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Training Investigative Letter

Name of applicant (please print) _____ Birth date _____

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 postgraduate training and return it directly to:

Board of Osteopathic Medicine and Surgery, P.O. 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.

Signature of applicant _____ Date _____

1. Is the applicant currently or has the applicant ever been engaged in postgraduate training in your program? Yes No Beginning Date _____ Ending Date _____

2. Briefly evaluate the applicant's competence and conduct during the program _____

3. Has the program ever had cause to restrict, suspend or terminate, or ask for a voluntary resignation of the applicant's participation in the program? Yes No If yes, explain and include performance evaluations. _____

4. 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, explain. _____

Name _____ Title _____

Facility _____ Telephone Number _____

Address _____

Authorized Signature _____ Date _____

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Hospital Investigative Letter

Name of applicant (please print) _____ Birth date _____

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, P.O. 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.

Signature of applicant _____ 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 (please print) _____ Birth date _____

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 state license and return it directly to:

Board of Osteopathic Medicine and Surgery, P.O. 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.

Signature of applicant _____ 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 _____

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Health Professions Reference Numbers and Links

RCW/WAC Links

Uniform Disciplinary Act (UDA).....	<u>RCW 18.130</u>
Administrative Procedure Act (APA)	<u>RCW 34.05</u>
Administrative procedures and requirements.....	<u>WAC 246-12</u>
Osteopathic Medicine and Surgery RCW.....	<u>RCW 18.57</u>
Osteopathic Medicine and Surgery WAC	<u>WAC 246-853</u>

Continuing Education

Osteopathic Continuing Medical Education Rules.....	<u>WAC 246-853-060-090</u>
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Online

Board of Osteopathic Medicine and Surgery	<u>Web page</u>
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