



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

## **Osteopathic Physician Assistant License Application Packet**

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These are the standard forms you should find within this application packet. Any forms may be copied as needed. There are more requirements for which there are no forms available; please read the instructions carefully in order to understand all that is required in order 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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Board of Osteopathic Medicine and Surgery  
P.O. Box 47877  
Olympia, WA 98504-7877  
360.236.4700

## 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: Professional Education:**  
List in chronological order your educational preparation and post-graduate training. If you need more space, attach a piece of paper.
- #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: Previous Licenses:**  
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.
- #6: Hospital Privileges:**  
List hospitals in the U.S. 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.
  - 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.
- #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](#).
- #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 a clear, close up and front view. Your application will not be processed without a current photograph.
- #9: Applicant's Attestation:**  
You must sign and date this for us to process the application. Read this very carefully.

## **License Requirements**

To qualify for your license, you must have graduated from a program approved by the board.

1. "Board approved program" means a physician assistant program accredited by:
  - a. The Committee on Allied Health Education and Accreditation (CAHEA).
  - b. The Commission on Accreditation of Allied Health Education Programs (CAAHEP).
  - c. The Accreditation Review Committee on Education for the Physician Assistant (ARC-PA).
  - d. Any successor accrediting organization using the same standards.
  - e. Pass the National Commission on Certification of Physician Assistant (NCCPA) examination within one year of graduation from a physician assistant program.

## **Initial Applicants Must Submit the Following Documents:**

1. Transcripts sent directly from your physician assistant program.
2. Verification letters sent directly to the board from all hospitals where you were granted privileges with in the past five years. If your last employment was in Washington State, verify any hospital privileges you had during your last practice relationship.
3. Verification letters sent directly from all states in which you have ever obtained a license to practice as a physician assistant (for example: PA, RN, LPN, etc.). Any Washington license will be verified directly from our data base.

**Note:** Some states require a processing fee. Check with each state to determine this fee.

4. If you are transferring from another Washington Physician, (either MD or DO), an evaluation letter is required from your most recent supervising physician.
5. Pass the National Commission on Certification of Physician Assistants, (NCCPA) examination. Show on the application if you are certified. Verification of certification will be obtained by staff.
6. A practice plan must be completed and approved by the board prior to beginning practice. If you are no longer working with an osteopathic physician supervisor you may either renew your license or let it expire. Keep in mind there will be more fees to reactivate your license in the future. You cannot practice in Washington without a license and practice plan with a supervising physician approved by either the board of Osteopathic Medicine and Surgery (osteopathic physician - DO) or the Medical Quality Assurance Commission (allopathic physician- MD).

**Note:** All documents must be originals. Copies or faxed documents will not be accepted.

## **Interim Permit**

An interim permit may be issued until the NCCPA certification has been obtained but no longer than one year. Upon receipt of the NCCPA certification, notify the board, and submit the fee to be issued a full license. You are required to have more frequent supervision, limited prescribing authority, and can not practice in a remote site. An interim permit is issued for one year and cannot be renewed.

## **Practice Plan Application**

1. Complete the Osteopathic Physician Assistant application form and submit the documents required for an original license or have a current osteopathic physician assistant license.
2. Completed practice plan.
3. If you transfer from a Washington physician supervisor (either MD or DO), you must have verification letters sent directly from all hospitals where you were granted privileges during the past working relationship.
4. Letter of evaluation from previous supervising physician.

## **Prescriptive Authority**

A certified osteopathic physician assistant or interim permit holder can issue written or oral prescriptions as provided in [WAC 246-854-030](#) when approved by the board and assigned by the supervising physician.

## **Supervision and Practice Responsibility**

The supervising osteopathic physician is responsible for adequate supervision and review of the osteopathic physician assistant's work. Only those tasks authorized by the board may be performed by the osteopathic physician assistant.

In the temporary absence of the supervising osteopathic physician, the osteopathic physician assistant may carry out those tasks for which they are licensed, if a delegated alternate physician supervisor or physician group provides supervision and review. The osteopathic physician assistant may not function if delegated alternate supervision and review are not available.

An M.D. can be the alternate supervisor for an osteopathic physician assistant licensed under the board.

The physician assistant can not advertise or mislead the public and must wear an identifying badge in a prominent place when meeting or treating patients. [WAC 246-854-015\(5\)\(e\)](#) and (f).

Following termination of supervision, the supervising physician and the osteopathic physician assistant must notify the board in writing within 30 days of the termination and include an explanation.

## **More Information**

Applications should be filed, complete with all supporting documents, at least 60 days before the license is needed. After initial review, more documents may be requested by the board. The board may conduct a background investigation on any applicant if documents raise questions relative to unprofessional conduct, incompetence or impairment. Applicants are advised that this process may take extra time to complete. When all required documents have been received, they will be reviewed for approval.

Licenses are renewed on the licensee's birthday each year by paying a renewal fee and completing the required fifty hours of continuing medical education. Failure to renew shall render the license invalid. Please keep the customer service center advised of any address changes so that you will receive your renewal notice.

The application process is considered confidential. Information about a pending application will only be provided to:

1. The applicant, information relative to osteopathic physician assistant practice plans may be made with the sponsor or alternate physician and the physician assistant.
2. A designated person identified and granted approval in writing by the applicant.

For more information, you may contact us at 360.236.4700.



## 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. Professional Education

List in chronological order your educational preparation and post-graduate training. If you need more space, attach a piece of paper.

Schools Attended Full Name, City and State	Degree Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

### 4. Professional Experience

List in chronological order all professional experience and practice from date of graduation from professional college. Include the month/day/year in chronological order. If you need more space, attach a piece of paper.

Name of Business	Total Number of Months	Dates	
		Start (mm/yyyy)	End (mm/yyyy)

### 5. Previous License

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. Attach more information, if necessary.

State Jurisdiction	Profession	License		Permanet or Temporary Yes <input type="checkbox"/> No <input type="checkbox"/>	Licence Method		Currently Enforce Yes <input type="checkbox"/> No <input type="checkbox"/>
		Year	Number		Exam	Other	
				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 <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 <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>

## 6. Hospital Privileges

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

Name of hospital (For locum tenens, enter only those of a 30-day or longer duration).	Dates attended	
	Start dd/mm/yyyy	End dd/mm/yyyy

## 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 education should have 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. **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 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  
(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



Board of Osteopathic Medicine and Surgery  
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360.236.4700

## Osteopathic PA Practice Plan

Name of P.A.		License #
Business address		
City	State	Zip
Telephone #	County	
<b>Supervising Osteopathic Physician</b>		
Physician name		License #
Business address		
City	State	Zip
Telephone #	County	
<b>Alternate Supervisor</b>		
Physician name		License #
Business address		
City	State	Zip
<b>Physician Group</b>		
Name of group		License #
Business address		
City	State	Zip
If alternate supervision is being provided by a physician group, outline how supervisory responsibility will be accomplished in the absence of the assigned supervisory osteopathic physician. _____ _____ _____ _____		
Last supervising physician _____		

# Osteopathic PA Utilization and Supervision

**Practice Settings**—Complete only those sections applicable to your practice.

**Office Practice Setting (Includes HMO):** Provide a brief summary of the general duties to be performed by the physician assistant in the office setting.

**Hospital Practice** (Note: All duties listed in this section may be approved by the Board but it is at the discretion of the hospital to allow them under its bylaws.)

Yes, the P.A. will practice in the following hospitals: (List names and cities)

Provide a brief summary of the general duties to be performed by the physician assistant in the hospital setting. In addition to the general duties, the osteopathic physician assistant will perform the following in the hospital setting: (Check only those you wish approved.)

Name of hospital	City

Writing orders in hospital charts which are by:

- Physician written standing orders.
- Physician verbal orders (indicated as such in the chart by P.A. signature and designation of who provided verbal order.)
- Physician assistant determination of need with follow-up by physician who co-signs within period of time designated by hospital.

These orders will include:

- Treatment plan
- Lab tests and X-rays
- Medications
- Other \_\_\_\_\_
- Assisting in surgery:
  - 1st assisting
  - 2nd assisting

P.A. will be assisting in the following surgical procedures:

- Major surgical procedures
- Minor surgical procedures
- Emergency Room—The P.A. will take a call in the hospital emergency room.

Describe how ER calls will be arranged and how supervision will be carried out and maintained. \_\_\_\_\_

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Nursing Home Practice (Note: All duties listed in this section may be approved by the Board, but it is at the discretion of the nursing home to allow them to be performed in its facility.)

Yes, the P.A. will practice in the following nursing home(s). (List names and cities.)

Name of nursing home	City

Provide a brief summary of the general duties to be performed by the physician assistant in the nursing home setting and how supervision will be accomplished. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Other Practice Areas:* List in this section any other areas the physician assistant will practice in (such as home health care, special clinics, schools, institutions, or special education clinics, etc.) Provide a brief summary of the general duties to be performed by the P.A. in each setting. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Indicate practice sites and percentage of time spent at each for both the P.A. and supervising physician.

Practice Sites	% of time for P.A.	% of time for D.O.
Clinic		
Hospital		
Institution		
Remote site		
HMO		
Nursing home		
Emergency room		
Other		

**Note:** Percentage of time should equal 100%.

## Supervision (Check those applicable to the P.A. practice)

- A. The osteopathic physician assistant will be in my regular city and area of practice and will be supervised by me as described below. I or the alternate supervisor(s) will be available for direct on-site or telephone consultation and supervision at all times when my physician assistant is on duty.
- B. The osteopathic physician assistant will be practicing in a remote site which is separate from my regular practice, and I will provide supervision by telephone, periodic visits, and other means of communication. Explain in detail in the Remote-Site section. The practice will be a full time practice for the physician assistant.
- C. The osteopathic physician assistant will be practicing part-time in a remote site. (Explain in detail in the Remote-Site section.) (check one)
- This is not my regular city/area of practice.
- This is my regular city/area of practice, but I will not be present for planned periods of time. For the part time remote practice supervision will be provided as explained in the Remote Site section. The remainder of the practice will be supervised as explained in A. and will be in the same city or another practice site as previously identified.
- D. Periods of Absence/Vacation (check one)—This section applies to both remote and direct supervision practices. When I am away from the office or practice location for any period of time, including vacation, continuing education or illness:
- A designated alternate supervisor(s)/physicians group will supervise the osteopathic physician assistant at all times in accordance with the practice description.
- My physician assistant will cease to function as such, as I have not designated any alternate supervising mechanism for my physician assistant.
- E. Chart Review (Check applicable category of license).
- Certified osteopathic physician assistant – Every written entry will be reviewed and countersigned within seven working days for the first 30 days for practice and 10% of charts thereafter, including clinic, emergency room, and hospital patients, within seven working days.
- Interim permit holder – Every chart entry shall be reviewed and countersigned within two working days.
- F. EKG's, x-rays, laboratory tests and special studies not read by a physician specialist shall be reported by the osteopathic physician assistant to the supervising osteopathic physician within 24 hours.

How many auxiliary health care providers do you supervise? \_\_\_\_\_

Number of P.A.'s \_\_\_\_\_ Other (Specify Job Titles) \_\_\_\_\_

Explain Level of Supervision required for other health care providers supervised. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Approximate number of patients to be seen weekly by P.A.? \_\_\_\_\_

If the alternate supervisor(s)/physician group are not located in the same office, where is his/her practice in relation to the P.A.'s setting(s)? \_\_\_\_\_

**Remote Site Section** A remote site is a practice location where the osteopathic physician is present less than 25% of the practice time of the certified osteopathic physician assistant.

Name of remote site		
Address of remote site		
City	State	Zip
Phone number		

Supply a detailed plan for supervision and chart review as provided in [WAC 246-854-015\(5\)](#) and (6). \_\_\_\_\_

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Include an explanation of the community need for utilization of the osteopathic physician assistant in the remote site. (Please see [WAC 246-854-025](#) Remote Practice Site – Utilization.) \_\_\_\_\_

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Explain the arrangement made for the osteopathic physician and certified osteopathic physician assistant to communicate in emergent situations. \_\_\_\_\_

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Outline the supervising osteopathic physician or alternate physician's plan for scheduled practice time with the osteopathic physician assistant in the remote site. \_\_\_\_\_

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We hereby certify under penalty of perjury under the laws of the State of Washington that the foregoing information in this practice plan is correct to the best of our knowledge and belief. We further certify we have reviewed the current rules and regulations of the Board of Osteopathic Medicine and Surgery pertaining to osteopathic physician assistants and this practice description and understand our roles and responsibilities.

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Signature of Physician Assistant

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Date

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Signature of Supervising Osteopathic Physician

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Date

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Signature of Alternate Physician  
(Only required if single alternate supervisor is listed)

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Date

Retain a copy of this Utilization Form as reference and guide for review by a Department of Health representative in the event of a site-review visit.



Board of Osteopathic Medicine and Surgery  
P.O. Box 47877  
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## **Standardized Procedures Reference and Guidelines**

The following is a list of board approved procedures for osteopathic physician assistants. Osteopathic physician assistants can provide the services they are able to perform based on their education, training and experience. The supervising osteopathic physician(s) and the osteopathic physician assistant shall determine which procedures may be performed. They also decide the degree of supervision to which the osteopathic physician assistant performs the procedure within the board's guidelines.

1. The procedure is performed under the general supervision and control of the supervising or alternate physician but does not necessarily require the presence of the supervising/alternate physician at the place where services are rendered.
2. The procedure is performed with the knowledge and concurrence of the supervising/alternate physician. The supervising/alternate physician must be present in the facility at the time the services are being rendered.
3. The physician assistant may directly assist the supervising/alternate physician with the procedure.

Board approval of hospital procedures are dependent upon approval by individual hospitals. Hospital by-laws and policies may not be consistent with board recommended procedures.

An osteopathic physician assistant may request permission to perform a specific procedure to a greater degree than indicated by the board. [WAC 246-854-010\(3\) and \(4\)](#). Indicate to what degree of supervision the procedure would be performed, provide an explanation of the reasons for the request and the osteopathic physician assistant's qualifications relative to performing that procedure. This criteria would apply to any procedures not listed.

## Hospital Procedures

Admit Patients .....	1
Emergency Room .....	1
History .....	1
PE .....	1
Admitting Diagnosis .....	1
Treatment .....	1
Emergency Room .....	1
Charting .....	1
Write Orders .....	1
Make Rounds .....	1
Write Discharge Summaries .....	1
Paracentesis .....	3
Chest Tubes .....	3
Foley Catheters .....	1
Arterial Lines .....	3
Swanz-Ganz Catheter .....	3
CVP .....	3
Order Blood Products .....	1
Order IV's .....	1
Change Dressings .....	1
Emergency Room Call with supervising physician in .....	1
hospital/backup .....	1
X-rays	
Order x-rays .....	1
Take x-rays .....	1
a. Routine .....	1
b. Special Procedures .....	1
Specify _____	1
Other (specify) _____	

## Surgery

Suturing .....	1
Remove Sutures .....	1
Operating Room	
Minor Surgery	
1st Assistant .....	1
2nd Assistant .....	1
Major Surgery	
1st Assistant .....	1
2nd Assistant .....	1
Pre-Op HX .....	1
Pre-Op PX .....	1
Post-Op Care .....	1
Dressing Changes .....	1
ICU Care .....	2
Sterilize Instruments .....	1
Set Up Trays .....	1
Prep Patients .....	1
Closure .....	1
Circumcisions (new born only) .....	2
Remove skin lesions .....	2
Biopsies .....	2
Other (specify) _____	

## Nursing Home Procedures

History .....	1
PE .....	1
Diagnosis .....	1
Treatment .....	1
Emergency Call .....	1
IV's .....	1
EKG's .....	1
Other (specify) _____	

## Office Procedures

Drawing Blood .....	1
Injections .....	1
IV Meds .....	1
Joint Injections or Taps .....	2
Diagnosis .....	1
Remove Cysts .....	2
Biopsies .....	2
Removing Lesions .....	2
Remove Warts .....	1
Ingrown Toenails .....	1
Cauterize Warts .....	1
I & D of Abscess .....	1
Fluorescein Stain Eyes .....	1
Pack Nose Bleeds .....	1
Wax Removal—Ears .....	1
Remove F.B.'s from Nose .....	1
Remove F.G.'s from Ears .....	1
Pierce Ears .....	1
Tonometry .....	1
Suturing Lacerations (uncomplicated) .....	1
Change Dressings .....	1
Take EKG's .....	1
Screen EKG's for abnormalities .....	1
Exercises Testing .....	2
Pulmonary Function Tests .....	1
Sigmoidoscopy .....	2
Remove Thrombosed Hemorrhoids .....	2
Prep for Cystoscopy .....	1
Care of Cystoscopic Instruments .....	1
Urethral Dilatation .....	2
Urine Catheterization .....	1
Bladder Taps .....	2
Diathermy—Ultrasound .....	1
Spinal Taps .....	3
Take x-rays .....	1
Order x-rays .....	1
Screen x-rays for abnormalities .....	1
Office Management .....	1
Maintain and Order Supplies .....	1
Other (specify) _____	

## Orthopedics

HX (Ortho) .....	1
PE (Ortho) .....	1
DX (Ortho) .....	1
Casting Non-displaced Fractures .....	1
Casting Sprains .....	1
Casting Displaced fractures after reduction.....	2
Reducing Fractures .....	2
Reducing Dislocated Shoulders .....	2
Reducing Dislocated Fingers/Toes .....	1
Removing Casts .....	1
Application of Traction Mechanisms .....	2
Spicas.....	2
Removal of Pins .....	2
Brace Fitting .....	2
Physical Therapy.....	1
Other (specify)_____	

## Exams

Complete Physical.....	1
Acute .....	1
Chronic .....	1
Emergency .....	1
Limited Physical.....	1
Other (specify)_____	

## Emergency

HX .....	1
PE.....	1
Diagnosis.....	1
Treatment and Plan .....	1
Cardioversion .....	1
Cardiac Resuscitation.....	1
Other (specify)_____	
Intubation.....	1
IV Cut Downs.....	1
Poisoning.....	1
NG Tube .....	1
Burns .....	1
Other (specify)_____	

## Counseling/Patient Education

Behavior Modification .....	1
Sex Counseling .....	1
Rape Counseling .....	1
Social Work (housing/food) .....	1
Nutrition .....	1
Long Term Therapy.....	1
Crisis Intervention.....	1
ETOH Referral.....	1
Treatment .....	1
Drug Abuse Counseling.....	1
Adolescence Counseling.....	1
Chronic Disease Education .....	1
Other (specify)_____	

## Lab

CBC's .....	1
Hematocrits .....	1
UA's .....	1
Gram Stains.....	1
Throat Cultures.....	1
Wet Mount .....	1

## Home Health

Home Visits .....	1
Home Treatment.....	1
Other (specify)_____	

## OB-Gyn

Prenatal .....	1
Prenatal Follow-up.....	1
Delivery.....	3
Emergency Only .....	1
Childbirth Education .....	1
Birth Control.....	1
Insert I.U.D.'s.....	2
Routine Paps and Pelvics.....	1
Other (specify)_____	

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

## Hospital Investigative Letter

Name of applicant (please print) \_\_\_\_\_ Birth date \_\_\_\_\_

I have applied for a license to practice as an osteopathic physician assistant 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 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 as an osteopathic physician assistant 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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Washington State Department of  
**Health**  
 Board of Osteopathic Medicine and Surgery  
 P.O. Box 47877  
 Olympia, WA 98504-7877  
 360.236.4700

## State License Investigative Letter

Name of applicant (please print) \_\_\_\_\_ Birth date \_\_\_\_\_

I have applied for a license to practice as an osteopathic physician assistant 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 to:

Department of Health  
 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 assistant'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 action 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.

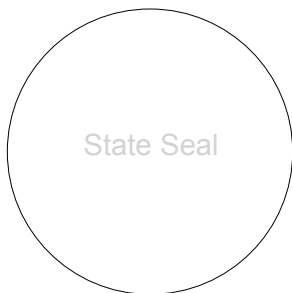
State Board \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Telephone Number \_\_\_\_\_

Authorized Signature \_\_\_\_\_

Date \_\_\_\_\_



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## Health Professions Reference Numbers and Links

### RCW/WAC Links

Uniform Disciplinary Act (UDA).....	<a href="#">RCW 18.130</a>
Administrative Procedure Act (APA).....	<a href="#">RCW 34.05</a>
Administrative procedures and requirements.....	<a href="#">WAC 246-12</a>
Osteopathic Physician Assistant RCW.....	<a href="#">RCW 18.57A</a>
Osteopathic Physician Assistant WAC.....	<a href="#">WAC 246-854</a>

### Continuing Education

Osteopathic Physician Assistant Continuing Medical Education Rules, Continuing Education .....	<a href="#">WAC 246-854-110</a>
Categories .....	<a href="#">WAC 246-854-115</a>

### Online

Board of Osteopathic Medicine and Surgery .....	<a href="#">Web page</a>
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