



Washington State Department of  
**Health**  
 Health Professions Quality Assurance  
 P.O. Box 1099  
 Olympia, WA 98507-1099

## **Expired Osteopathic Physician Assistant Credential Reactivation Application Packet Contents:**

- 1. 663-661 ... Contents List/SSN Information/Mailing Information ..... 1 page
- 2. 663-662 ... Application for Credential Activation to Practice as a Certified Osteopathic Physician  
 Assistant ..... 4 pages
- 3. 663-056 ... Application Instructions Checklist ..... 3 pages
- 4. 663-043 ... Osteopathic Physician Assistant Practice Plan..... 6 pages
- 5. 663-046 ... Physician Assistant Standardized Procedures Reference and Guidelines ..... 3 pages
- 6. 663-047 ... Hospital Investigative Letter ..... 1 page
- 7. 663-048 ... State Licensure Investigative Letter ..... 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 360.236.4700 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 your check or money order payable to:**

Department of Health  
 PO Box 1099  
 Olympia, WA 98507-1099

### **Send additional documents to:**

Osteopathic Program  
 PO Box 47877  
 Olympia, WA 98504-7877

### **Contact us:**

360.236.4700

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Washington State Department of  
**Health**  
Health Professions Quality Assurance  
P.O. Box 1099  
Olympia, WA 98507-1099

| FOR OFFICE USE ONLY |      |
|---------------------|------|
| LICENSE NUMBER      | DATE |

## Application for Credential Activation for Expired Certified Osteopathic Physician Assistant

LICENSE #

Application for (check one):  Expired over 1 year, less than 3 years  
 Expired over 3 years

**Please Type or Print Clearly**—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Supporting documents should be filed with the Health Professions Quality Assurance Division at least sixty (60) days before license is needed. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by applicable fee (fees are nonrefundable). For applicable fee, please see instructions. Mail remittance payable to Department of Health, Revenue Section.

**NOTE:** The mailing address you provide will be listed on your license and all correspondence from the Department will be sent to this address until you notify us of a change.

### 1. Demographic Information

|  |        |                                   |                |  |  |
|--|--------|-----------------------------------|----------------|--|--|
| APPLICANT'S NAME LAST  |        | FIRST                             |                | MIDDLE INITIAL   |  |
| MAILING ADDRESS  |        |                                   |                |  |  |
| CITY   |        | STATE                             | ZIP            | COUNTY   |  |
| BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING <b>NORMAL BUSINESS HOURS</b> )<br>(      ) |        | RESIDENCE TELEPHONE<br>(      )   |                | SOCIAL SECURITY NUMBER ( <b>Required</b> for license under 42 USC 666 and Chapter 26.23 RCW)<br>—      — |  |
| GENDER<br><input type="checkbox"/> Female <input type="checkbox"/> Male  |        | BIRTHDATE (MO/DAY/YR)<br>/      / |                | PLACE OF BIRTH (CITY/STATE)  |  |
| HEIGHT   | WEIGHT | EYE COLOR                         | HAIR COLOR     |  |  |
| PHYSICIAN'S ASSISTANT PROGRAM  |        |                                   | YEAR GRADUATED |  |  |
| PROGRAM ADDRESS  |        | CITY                              | STATE          |  |  |

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—not profile
5. Instant Polaroid Photographs **not** acceptable

### 2. Previous Licensure – Physician Assistant

List all licenses granted with type, date, jurisdiction, and if license is current. Include all states where previously licensed.

| STATE OR OTHER | PROFESSION | CERTIFICATE |        | PERMANENT OR TEMPORARY                                      | LICENSE RECEIVED BY |       | CURRENTLY IN FORCE                                       |
|----------------|------------|-------------|--------|---|---------------------|-------|--|
|                |            | YEAR        | NUMBER |   | EXAMINATION         | OTHER |  |
|                |            |             |        | <input type="checkbox"/> Perm <input type="checkbox"/> Temp |                     |       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                |            |             |        | <input type="checkbox"/> Perm <input type="checkbox"/> Temp |                     |       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                |            |             |        | <input type="checkbox"/> Perm <input type="checkbox"/> Temp |                     |       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                |            |             |        | <input type="checkbox"/> Perm <input type="checkbox"/> Temp |                     |       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                |            |             |        | <input type="checkbox"/> Perm <input type="checkbox"/> Temp |                     |       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                |            |             |        | <input type="checkbox"/> Perm <input type="checkbox"/> Temp |                     |       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                |            |             |        | <input type="checkbox"/> Perm <input type="checkbox"/> Temp |                     |       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### 3. 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 explain.....
- “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.
- 1a. If you answered “yes” to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).
- 1b. If you answered “yes” to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.
- (If you answered “yes” to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in “1b” so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)
2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.....
- “Currently”** means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.
- “Chemical substances”** includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.
3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?.....
4. Are you currently engaged in the illegal use of controlled substances?.....
- “Currently”** means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.
- “Illegal use of controlled substances”** means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with 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, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:
- a. the use or distribution of controlled substances or legend drugs?.....
- b. a charge of a sex offense?.....
- c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving).....
6. Have you ever been found in any civil, administrative or criminal proceedings 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, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? .....
- b. committed any act involving moral turpitude, dishonesty or corruption? .....
- c. violated any state or federal law or rule regulating the practice of a health care professional? .....
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”, explain 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, or have you ever surrendered such credential to avoid or in connection with action by such authority?.....
9. 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?.....



## 6. AIDS Education and Training Attestation

I certify I have completed the minimum of 7 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

DATE

## 7. Applicant's Attestation

I, \_\_\_\_\_, certify that I am the person described and identified  
NAME OF APPLICANT

in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

**Official Use Only**

**Washington State Records Center**

## **Instructions for Credential Activation Osteopathic Physician Assistant**

When your application for expired credential activation is received by the Department of Health, Board of Osteopathic Medicine and Surgery, you will be sent an acknowledgment letter noting receipt, and any outstanding documentation needed to complete the process.

### **Reactivation Applicants Must Submit:**

1. Completed Washington Osteopathic Physician Assistant application form.  
“Yes” responses to any of the questions in the Personal Data section of the application must be accompanied by documentation as stated on the application form and a brief explanation regarding your particular circumstance.
2. **Pay** Late Penalty Fee.  
**Pay** Current Renewal Fee.  
**Pay** Expired Credential Reissuance Fee.  
**All fees are non-refundable.** These fees are located on the Board of Osteopathic Medicine and Surgery [fee page](#).
3. Signed affidavit indicating completion of seven hours of AIDS education.
4. Verification letters sent directly to us from all hospitals where applicant has been granted privileges for the past five (5) years.
5. Verification letters sent directly from all states in which you have ever obtained a health care license (for example: PA, RN, LPN, etc.).  
(Some states require a fee for processing verification letters. Please check with each state to determine this fee.)
6. A practice plan must be completed and approved prior to beginning practice. A license may be renewed and kept current without an approved practice plan with an osteopathic physician supervisor, but the physician assistant may not practice.

### **Practice Plan Application**

1. Completed Washington Osteopathic Physician Assistant application form or have a current osteopathic physician assistant license.  
“Yes” responses to any of the questions in the Personal Data section of the application must be accompanied by documentation as stated on the application form and a brief explanation regarding your particular circumstances.
2. Practice Plan application fee located at on the Board of Osteopathic Medicine and Surgery [fee page](#).

3. Completed practice plan
4. Letter of evaluation from previous supervising physician, if transferring from an MD supervising physician.

## **Prescriptive Authority**

A certified osteopathic physician assistant or interim permit holder may issue written or oral prescriptions as provided in WAC 246-854-030 when approved by the Board and assigned by the supervising physician.

If an applicant has had a name change or documents were issued in a name other than the one currently being used, please indicate those names when submitting the application file.

Applications should be filed, complete with all supporting documents, at least 30 days before the license is needed. After initial review, additional documentation or information may be requested by the board. The Board of Osteopathic Medicine and Surgery 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 additional time to complete.

When all required documentation has been received, applications will be reviewed for approval.

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

It is the supervising physician's responsibility to assure that the best interests of the patients are served by utilizing a physician assistant, and that adequate supervision and review of the physician assistant's work is provided. Only those tasks authorized by the Board may be performed by the physician assistant.

In temporary absence of the supervising physician, the physician assistant may carry out those tasks for which they are licensed, if the supervisory and review mechanisms are provided by a delegated alternate physician supervisor or physician group. The physician assistant may not function as such if these supervisory and review functions are unavailable.

An M.D. may be the alternate supervisor for a physician assistant licensed under the Board of Osteopathic Medicine and Surgery.

The physician assistant may not advertise or mislead the public to his or her role and must wear identifying badges 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 date of the working relationship and include the reasons.

Licenses are renewed on the licensee's birthday each year by paying a renewal fee. Failure to renew shall render license invalid. Fifty hours of continuing medical education will be required for renewal annually. Please keep the Board office advised of any address changes so that you will receive your renewal notice.

The current residential address and telephone number of healthcare provider governed under Chapter 18.130 RCW is not releasable as public information.

The application process is considered confidential. Information about a pending application will only be provided to: 1) the applicant, (communications relative to osteopathic physician assistant practice plans may be made with the sponsor or alternate physician and the physician assistant, or 2) a designated representative identified and granted approval in writing by the applicant.

For additional information you may contact our office at (360) 236-4943.

**Send all supporting documents to:**

Licensing Representative  
Board of Osteopathic Medicine and Surgery  
PO Box 47866  
Olympia, Washington 98504-7866  
(360) 236-4943

**Send application and fee to:**

Licensing Representative  
Board of Osteopathic Medicine and Surgery  
PO Box 1099  
Olympia, Washington 98507-1099

**Renewal information and  
Osteopathic Physician Assistant  
Application Packets:**

Customer Service Center  
(360) 236-4700  
Email: [hpqa.csc@doh.wa.gov](mailto:hpqa.csc@doh.wa.gov)

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# Osteopathic Physician Assistant Practice Plan

|                  |        |             |
|------------------|--------|-------------|
| NAME OF P.A.     |        | LICENSE NO. |
| BUSINESS ADDRESS |        |             |
| CITY             | STATE  | ZIP         |
| TELEPHONE NO.    | COUNTY |             |

## Supervising Physician

|                  |        |             |
|------------------|--------|-------------|
| PHYSICIAN NAME   |        | LICENSE NO. |
| BUSINESS ADDRESS |        |             |
| CITY             | STATE  | ZIP         |
| TELEPHONE NO.    | COUNTY |             |

## Alternate Supervisor

|                  |       |             |
|------------------|-------|-------------|
| PHYSICIAN NAME   |       | LICENSE NO. |
| BUSINESS ADDRESS |       |             |
| CITY             | STATE | ZIP         |

## Physician Group

|                   |       |             |
|-------------------|-------|-------------|
| NAME OF THE GROUP |       | LICENSE NO. |
| 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.

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LAST SUPERVISING PHYSICIAN \_\_\_\_\_

## Osteopathic Physician Assistant 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 that 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.

| NAME OF HOSPITAL | CITY |
|------------------|------|
|                  |      |
|                  |      |
|                  |      |

In addition to the general duties, the physician assistant will perform the following in the hospital setting: (Check only those you wish approved.)

- 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 call will be arranged and how supervision will be carried out and maintained. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Nursing Home Practice* (Note that 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.

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*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.

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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. My 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. My 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. My 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 in \_\_\_\_\_ (list site).
- 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 my 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 7 working days for the first 30 days for practice and 10% of charts thereafter, including clinic, emergency room, and hospital patients, within 7 working days.
- Interim permit holder – Every chart entry shall be reviewed and countersigned within 2 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 CODE |
| 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 a 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 Physician

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Date

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Signature of Alternate Physician  
(only if single alternate is indicated)

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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.**



Washington State Department of

**Health**

Board of Osteopathic Medicine and Surgery

P.O. Box 47866

Olympia, WA 98504-7866

(360) 236-4943

## **Physician Assistant Standardized Procedures Reference and Guidelines**

The following is a list of Board approved procedures for physician assistants. Physician assistants may provide those services that they are competent to perform based on their education, training, and experience. The supervising physician(s) and the physician assistant shall determine which procedures may be performed and the degree of supervision to which the physician assistant performs the procedure within the Board's recommended guidelines.

1. The procedure is performed under the general supervision and control of the supervising or alternate physician but does not necessarily require the personal 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.

A physician assistant may request permission to perform a specific procedure to a greater degree than indicated by the Board. WAC 246-854-020(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 physician assistant's qualifications relative to performing that procedure. This criteria would also 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 ..... | 1 |
| supervising physician in ..... | 1 |
| hospital/backup .....          | 1 |
| X-rays .....                   | 1 |
| 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 .....                | 1 |
| 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<br>after reduction ..... | 2 |
| Reducing Fractures .....                             | 2 |
| Reducing Dislocated Shoulders .....                  | 2 |
| Reducing Dislocated Fingers/Toes .....               | 1 |
| Removing Casts .....                                 | 1 |
| Application of Traction<br>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<br>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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Washington State Department of

Health

Board of Osteopathic Medicine and Surgery

P.O. Box 47866

Olympia, WA 98504-7866

(360) 236-4943

# Hospital Investigative Letter

NAME OF APPLICANT (Please Print)

BIRTHDATE (MONTH/DAY/YEAR)

I have applied to the Washington State Board of Osteopathic Medicine and Surgery for a license to practice as an osteopathic physician assistant. 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 47866  
Olympia, Washington 98504-7866  
(360) 236-4943

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 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 \_\_\_\_\_

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

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

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

Date \_\_\_\_\_

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Washington State Department of

Health

Board of Osteopathic Medicine and Surgery

P.O. Box 47866

Olympia, WA 98504-7866

(360) 236-4943

# State Licensure Investigative Letter

NAME OF APPLICANT (Please Print)

BIRTHDATE (MONTH/DAY/YEAR)

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 licensure and return it directly to:

Board of Osteopathic Medicine and Surgery  
PO Box 47866  
Olympia, Washington 98504-7866  
(360) 236-4943

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 physician assistant's application, we would appreciate receiving the following information.

Licensed as \_\_\_\_\_

License Number \_\_\_\_\_ Date license was issued \_\_\_\_\_

Is license current?  Yes  No

Has the applicant's license ever been suspended or revoked, or has any other disciplinary action been taken?

Yes  No

If yes, for what reason? \_\_\_\_\_

Please attach copies of any disciplinary orders or any other pertinent information and documents.

Authorized Name \_\_\_\_\_

Title \_\_\_\_\_

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

**State Seal**

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

Date \_\_\_\_\_