



Washington State Department of
Health
 Board of Physical Therapy
 PO Box 47877
 Olympia, WA 98504-7877
 360.236.4700

Physical Therapist Expired Credential Activation Application Packet

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Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with Initial documentation and your check or money order payable to:

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

Send other documents not sent with initial application to:

Board of Physical Therapy
 PO Box 47877
 Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

You will be notified in writing if more documentation is needed. Please do not call to check on the status of an application. This will allow program staff to prepare your file for reactivation.

To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- Pay Late Penalty Fee.**
- Pay Current Renewal Fee.**
- Pay Expired Credential Reissuance Fee. All fees are non-refundable.** You can check the [fee page](#) for current fees.
- #1 Demographic Information.**

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

- #2 Previous Credentialing.** List **all** licenses you have held since last being licensed in Washington State. List in chronological order, most current first. Include your last active license in Washington State. If you need more space, attach a piece of paper.
- #3 Professional Experience.** In chronological order, list all your professional work experience since your Washington State credential expired. If you need more space, attach a piece of paper.
- #4 AIDS Education and Training Attestation.** Required by [WAC 246-12-040](#).
- #5 Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- #6 Continuing Education Attestation.** Required by [WAC 246-12-040](#).
- #7 Applicant's Attestation.** Required to be both signed and dated in order to process the application.

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Physical Therapist Expired Credential Activation Application

Please type or print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could result in a delay in processing your application. Make sure you read the instructions.

1. Demographic Information

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

Male
 Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City

State

Country

Address

City State Zip County

Country

Phone () Fax () Cell ()

Email address

Mailing address (if different from above)

City State Zip County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? Yes No If yes, list name(s):

Will documents be received in another name? Yes No

If yes, list name(s): _____

For Office Use Only

Certificate # _____ Issue Date _____

Validation Date _____ Received _____

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

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently In Force	
		Type	Number	Year Issued		No	Yes

3. Professional Experience

Nature of experience of practice and location	start (mm/yyyy)	end (mm/yyyy)

4. AIDS Education and Training Attestation

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

Applicant's Initials	Date
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5. Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

Applicant's Initials	Date
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6. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify that I have met all continuing education (40 hours) and competency (200 employment hours) requirements for the past two years.

Applicant's Initials	Date
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7. 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

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Board of Physical Therapy
 PO Box 47877
 Olympia, WA 98504-7877
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Board of Physical Therapy Verification of Electroneuromyographic Training by a Qualified Provider

This form may be duplicated. Fill out Section 1 and forward the verification form to the qualified provider for completion.

1. Applicant (print or type clearly)

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

2. Qualified Provider

A qualified provider includes a physical therapist with board certification in clinical electrophysiology from the American Board of Physical Therapy Specialties, a neurologist, a physiatrist, or a person who is board certified in clinical electrophysiology from the American Board of Physical Therapy Specialties.

The above individual seeks verification of training by a qualified provider to place an electroneuromyographic endorsement on his/her physical therapy license. Please complete the following:

Qualified Provider's Name _____ Current Phone _____

Current Street Address _____

City _____ State _____ Zip _____

Provider's License Type and License Number _____ Dates Licensed _____

3. Education and Training

A minimum of four hundred hours of electroneuromyographic training is required. Training includes at least two hundred needle EMG studies under direct supervision from a qualified provider.

Hours mentored _____ Describe the activities mentored _____

Qualified Provider/Mentor

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Signature _____ Date _____

Return this form to the above address.

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Board of Physical Therapy Verification of Mentored Sharp Debridement Education and Training

This form may be duplicated. Fill out Section 1 and forward the verification form to the qualified provider for completion.

1. Applicant (print or type clearly)

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

2. Approved Mentor

The above individual seeks verification of training by a qualified provider to place an electroneuromyographic endorsement on his/her physical therapy license. Please complete the following:

Mentor Name _____ Current Phone _____

Current Street Address _____

City _____ State _____ Zip _____

Mentor's License Type and License Number _____ Dates Licensed _____

3. Mentored Education and Training Specific to Sharp Debridement

A minimum of twenty hours of mentored sharp debridement and training is required. Mentored training includes observation, co-treatment and supervised treatment. Twenty hours mentored training in a clinical setting must include a case mix similar to the physical therapists' expected practice.

Hours mentored _____ Describe the activities mentored _____

Mentor

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Signature _____ Date _____

Return this form to the above address.