



## **Health Care Assistant Certification Application Packet**

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### **Important Social Security Number Information:**

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:**

Health Care Assistant Credentialing  
PO Box 47877  
Olympia, WA 98504-7877

**Contact us:**

360.236.4700

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## **Health Care Assistant Certification Education Requirements for Categories A through F**

Washington Administrative Code, chapter 246-826, specifically, [WAC 246-826-130](#) through [WAC 246-826-180](#) identify categories A through F. Each category identifies the education, work experience, and training required for the specific category.

The Department of Health requires an **official** transcript.

**Note: If your transcripts do not clearly identify that you have taken all of the required courses, provide course description(s) identifying which classes in your transcripts covered those subjects.**

### **[WAC 246-826-130](#) Category A minimum requirements.**

Category A, to perform venous capillary blood draw; administration of oral, topical, and nasal vaccines.

**Education:** High school education or equivalent. No additional education is required.

### **[WAC 246-826-140](#) Category B minimum requirements.**

Category B, to perform arterial blood draw; administration of oral, topical, and nasal vaccines.

**Education:** Minimum high school education or equivalent with additional education to include but not be limited to anatomy, physiology, concepts of asepsis, and microbiology.

### **[WAC 246-826-150](#) Category C minimum requirements.**

Category C, to perform intradermal (including skin tests), subcutaneous, and intramuscular injections for diagnostic agents; administration of oral, topical, and nasal vaccines and approved drugs restricted to topical, rectal, oral, otic, ophthalmic, or inhaled routes.

**Education:** One academic year of formal education at the post-secondary level. Education shall include, but not be limited to, anatomy, physiology, basic pharmacology, concepts of asepsis, and microbiology.

### **[WAC 246-826-160](#) Category D minimum requirements.**

Category D, to perform intravenous injections for diagnostic agents; administration of oral, topical, and nasal vaccines.

**Education:** Two academic years of formal education at the post-secondary level. Education shall include, but not be limited to, anatomy, physiology, basic pharmacology, mathematics, chemistry, concepts of asepsis, and microbiology.

**WAC 246-826-170 Category E minimum requirements.**

Category E, to perform intradermal (including skin tests), subcutaneous, and intramuscular injections for therapeutic agents; administration of oral, topical, and nasal vaccines and approved drugs restricted to topical, rectal, oral, otic, ophthalmic, or inhaled routes.

**Education:** One academic year of formal education at the post-secondary level. Education shall include, but not be limited to, anatomy, physiology, pharmacological principles and medication administration, mathematics, concepts of asepsis, and microbiology.

**WAC 246-826-180 Category F minimum requirements.**

Category F, to perform intravenous injections for therapeutic agents; administration of oral, topical, and nasal vaccines.

**Education:** Two academic years of formal education at the post-secondary level. Education shall include, but not be limited to, anatomy, physiology, pharmacological principles and medication administration, mathematics, chemistry, concepts of asepsis, and microbiology.

# **Health Care Assistant Certification Education Requirement Category G Hemodialysis**

Category G may perform:

- Venipuncture for blood draw
- Administration of oxygen as necessary by cannula or mask
- Venipuncture or placement of fistula needles
- Connect to vascular catheter for hemodialysis
- Administration of oral, topical, and nasal vaccines
- Intravenous administration of heparin and sodium chloride solutions as an integral part of dialysis treatment
- Intradermal, subcutaneous, or topical administration of local anesthetics in conjunction with placement of fistula needles
- Intraperitoneal administration of sterile electrolyte solutions
- Heparin for peritoneal dialysis

Washington Administrative Code, chapter [246-826](#), specifically, [WAC 246-826-301](#), [WAC 246-826-302](#), and [WAC 246-826-303](#) identify category G, minimum requirements to perform hemodialysis, minimum training standards for mandatory hemodialysis technician training programs, and minimum standards of practice and core competencies of hemodialysis technicians.

The Department of Health requires verification from the Preceptor that you:

- completed six to eight weeks of training in both didactic and supervised clinical instruction, as required by [WAC 246-826-302](#).
- meet the minimum standards of practice and core competencies of hemodialysis technicians as required by [WAC 246-826-303](#).

[WAC 246-826-301](#) Hemodialysis technician, category G minimum requirements to perform hemodialysis.

[WAC 246-826-302](#) Minimum training standards for mandatory hemodialysis technician training programs.

[WAC 246-826-303](#) Minimum standards of practice and core competencies of hemodialysis technicians.

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## Application Instruction 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 in blue or black ink. It is your responsibility to submit the required forms.

**Application Fee: (This fee is non-refundable).** You can check the online [fee page](#) for current fees.

**Categories:** Please indicate categories you wish to apply for. See [Education Requirements](#) for definitions of categories.

**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: first, middle, and last.

**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 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 month, day, and year you were born.

**Birth place:** 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 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](#).

**Facility/Delegator:** The delegator must be a medical doctor (MD), osteopathic doctor (DO), podiatric doctor (DPM), physician assistants (PA), advanced registered nurse practitioner with prescriptive authority (ARNP) or naturopathic doctor (ND) licensed in Washington State. Delegator name, license number and expiration date must be listed.

**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 provide the documentation listed in the note after the questions. 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 obtain 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: Training and Education**

List in date order your training and education. If you need more space, attach a piece of paper. For categories B, C, D, E or F, we require official transcripts be sent directly from your school to the Department of Health.

**4: Experience**

List in date order your professional work experience. Attach additional pages if you need more space.

**5: Other License, Certification, or Registration**

List all states, including Washington State, where credentials are or were held. Specifically list credentials granted by examination, endorsement, or grandparented.

An Out-of-State Credential Verification form is enclosed and must be sent to each state you listed. Enter your full name and birth date at the top of the form so the state can identify you. Also contact each state board listed for any fees they may charge for processing the verification.

**6: Preceptor Attestation for Hemodialysis Technician**

The preceptor supervises, trains, or observes a student giving direct patient care in a dialysis facility. The preceptor must be a medical doctor (MD), osteopathic doctor (DO), advanced registered nurse practitioner with prescriptive authority (ARNP) or registered nurse (RN) licensed in Washington State. Preceptor name, license number and expiration date must be listed.

**7: Aids Education and Training Attestation**

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in [WAC 246-12-270](#).

**8: Delegator Attestation**

The delegator must attest to the applicant’s education, work experience, clinical training, and supervision.

**9: Medication and Diagnostic Agent List**

For categories A, B, C, D, E, F, and G, list medication and the specific route.

**10: Applicant Attestation and Signature**

You must sign and date this for us to process the application.

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required.

**Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington**

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at <http://www.doh.wa.gov/hsga/professions/military/> and include supporting documentation with your application.

**Other Information:**

Criminal history checks are conducted for all license applicants. If you answered yes to any of the personal data questions, please submit the appropriate supporting documentation as indicated on the application. If your application is incomplete, you will be mailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.
- The initial certification will expire two years from the date of issuance.
- Certifications must be renewed every two years as provided in chapter [246-12 WAC, Part 2](#). A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding the home care aid program is available on our [Web site](#).

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# Application for Certification as a Health Care Assistant

Categories (check all that apply) See [Education Requirements](#) for definitions of categories.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> A. Venous capillary blood draw, administration of oral, topical, and nasal vaccines.  | <input type="checkbox"/> D. Intravenous injections for diagnostic agents, administration of oral, topical, and nasal vaccines.   | <input type="checkbox"/> F. Intravenous injections for therapeutic agents, administration of oral, topical, and nasal vaccines. |
| <input type="checkbox"/> B. Arterial blood draw, administration of oral, topical, and nasal vaccines.  | <input type="checkbox"/> E. Skin tests and injections for therapeutic agents and administration of oral, topical, and nasal vaccines and approved drugs restricted to oral, topical, rectal, otic, ophthalmic or inhaled routes. | <input type="checkbox"/> G. Hemodialysis, administration of oral, topical, and nasal vaccines.                                  |
| <input type="checkbox"/> C. Skin tests and injections for diagnostic agents and administration of oral, topical, and nasal vaccines and approved drugs restricted to |  |   |

## 1. Demographic Information

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

Name  Mr. First Middle Last  
 Ms.

Birth date (mm/dd/yyyy) **Place of Birth**  
City State Country

Address City

State Zip Code County

Phone (enter 10 digit #) Fax (enter 10 digit #) Cell (enter 10 digit #)

Email Address:

Have you ever been known under any other name(s)?  
If yes, list name(s):

Will documents be received in another name?  
If yes, list name(s):

### Facility/Delegator Information

Facility Name

Facility Mailing Address

City State

Zip code County

Delegator is (Check One)  MD  DO  DPM  PA  ARNP/PR Authority  ND

Delegator Name

Delegator License Number License Expiration Date

### For Office Use Only

Credential # \_\_\_\_\_ Issue Date \_\_\_\_\_

## 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, intellectual disabilities, 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? .....

## 3. Training and Education

List in date order your training and education. Attach additional pages if you need more space.

Full Name, City and State/Schools Attended	Degree Earned	Attendance	
		Entrance Date	Ending Date

## 4. Experience

List in date order your work experience. Attach additional pages if you need more space.

Name and Location of Institution	From (mm/dd/yy)	To (mm/dd/yy)	Type of Experience or Speciality

## 5. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held.

State/Jurisdiction	Credential Type	Credential		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grandparented

## 6. Preceptor Attestation for Hemodialysis Technician—Category G Only

The hemodialysis technician, category G assistant shall receive training, evaluation(s), and assessment of knowledge skills to determine minimum level competency.

I, \_\_\_\_\_  
Preceptor Name—Type or Print

(Who supervises, trains, or observes student providing direct patient care in a dialysis facility or center)

verify that \_\_\_\_\_  
Hemodialysis Technician—Type or Print

completed six to eight weeks of training in both didactic and supervised clinical instruction, as required by [WAC 246-826-302](#).

\_\_\_\_\_  
Signature of Preceptor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Preceptor License #

\_\_\_\_\_  
Expiration Date

## 7. Aids Education and Training Attestation

I certify I have completed the minimum of seven 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 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.**

- School curriculum  
 Employer/Other

Applicant's Initials	Date

## 8. Delegation of Procedures

I, \_\_\_\_\_,  
Delegator Name—Type or Print

(Must be an MD, DO, DPM, PA, ARNP/PR authority, or ND)

verify that \_\_\_\_\_  
Health Care Assistant Name—Type or Print

may be delegated the authority to perform procedures applicable to the categories indicated. I attest that documentation of specific medications/diagnostic agents and routes of administration are authorized for this individual. Any alteration to the medication list will be provided to the Department of Health under my and the health care assistant's signatures within 30 days of the change.

I certify the health care assistant has met the required educational, clinical training, instruction, and work experience applicable for the categories indicated.

I certify appropriate supervision will be provided to the health care assistant in carrying out the procedures delegated.

Original Signature of Delegator \_\_\_\_\_ Date \_\_\_\_\_

## 9. Medication and Diagnostic Agent List—Categories A, B, C, D, E, F, and G

Any changes of the medication list must be reported to the Department of Health within 30 days following the change. Additional medication/diagnostic agents may be listed on additional pages.

**Note: Oral vaccines can be administered by all categories. Medications can only be administered by categories C and E, as set in [RCW 18.135.130](#).**

Medications/Diagnostic Agents to be Administered Include	VIA (Route)
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I attest this health care assistant has demonstrated initial competency to administer the drugs listed above.

\_\_\_\_\_  
Delegator Name (Type or Print)

\_\_\_\_\_  
Health Care Assistant Name (Type or Print)

\_\_\_\_\_  
Original Signature of Delegator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Original Signature of Health Care Assistant

\_\_\_\_\_  
Date

WAC 246-826-100 remains in effect regarding the administration of vaccines by a health care assistant:  
<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-826-100>.

WAC 246-926-200 remains in effect regarding drug injections which may be administered by health care assistants categories C, D, E or F:

<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-826-200>.

Effective July 22, 2011, legislation amends the scope of practice of health care assistants to allow only categories C and E to administer certain drugs:

Per RCW 18.135 Amended Section:

The administration of drugs by a health care assistant is restricted to oral, topical, rectal, otic, ophthalmic, or inhaled routes administered pursuant to a written order of a supervising health care practitioner. The drugs authorized for administration under this section are limited to the following:

Over-the-counter drugs that may be administered to a patient while in the care of a health care practitioner are: benadryl, acetaminophen, ibuprofen, aspirin, neosporin, polysporin, normal saline, colace, kenalog, and hydrocortisone cream.

Nonover-the-counter unit dose legend drugs that may be administered to a patient while in the care of a health care practitioner are: Kenalog, hydrocortisone cream, raglan, compazine, zofran, bactroban, albuterol, xopenex, silvadene, gastrointestinal cocktail, fluoride, 1mx cream, emla, lat, optic eyes, oral contrast, and oxygen.

## 10. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of Washington that the following is true and correct:  
Name of Applicant

- 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 \_\_\_\_\_  
mm/dd/yyyy City, state

by: \_\_\_\_\_  
Original Signature of Applicant

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Washington State Department of

**Health**

Health Care Assistant Credentialing

PO Box 47877

Olympia, WA 98504-7877

360.236.4700

## **Out-of-State Credential Verification**

### **To Applicant:**

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered. Instruct them to return the form directly to the address listed below. Licensing agencies normally charge a fee to verify a credential, please check in advance to help expedite this process. This form may be duplicated.

Name: Last		First	Middle
Mailing Address			
City		State	Zip Code
Any other names used:			
Credential Number			Date Issued

Have the licensing agency return this completed form to the address listed above.

**(To be Completed by the Regulatory Agency)**

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of credential holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by: <input type="checkbox"/> Written Examination	Date:	Score:
Name of examination:		
<input type="checkbox"/> Other Examination	Date:	Score:
Name of examination:		
Is credential current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration Date:	
Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no", please attach explanation.		
Has this credential ever been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No Suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No Revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No Surrendered? <input type="checkbox"/> Yes <input type="checkbox"/> No Reinstated? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

(SEAL)

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Title:

\_\_\_\_\_  
Date:



## **RCW/WAC and Online Web Site Links**

### **RCW/WAC Links**

Uniform Disciplinary Act.....	<a href="#"><u>RCW 18.30</u></a>
Administrative Procedure Act .....	<a href="#"><u>RCW 34.05</u></a>
Health Care Assistant Law .....	<a href="#"><u>RCW 18.135</u></a>
Health Care Assistant Rules.....	<a href="#"><u>WAC 246-826</u></a>

### **On-line**

AIDS Training Resources .....	<a href="#"><u>Reference Page</u></a>
Health Care Assistant Web Page.....	<a href="http://www.doh.wa.gov/hsqa/professions/Health_Care/default.htm"><u>http://www.doh.wa.gov/hsqa/professions/Health_Care/default.htm</u></a>

### **List-Serv**

To receive emails regarding important health care assistant information,  
please join our interested parties at..... [List-Serv](#)