



## **Veterinary Medication Clerk Expired Registration Activation 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, please 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  
P.O. Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Veterinary Board of Governors  
Credentialing  
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. 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 online [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: 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 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. Other License, Certification, or Registration.** List **all** licenses you have held since last being licensed in Washington State. List in date order, most current first. Include your last active license in Washington State. Attach additional completed pages if you need more space.
- 3. Experience.** In date order, list all your professional work experience since your Washington State credential expired. Attach additional completed pages if you need more space.
- 4. AIDS Education and Training Attestation.** Required by [WAC 246-12-040](#).
- 5. Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- 6. Applicant’s Attestation.** Required to be both signed and dated in order to process the application.

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## Veterinary Medication Clerk Expired Registration Activation Application

Please type or print clearly. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so may result in a delay in processing your application.

### 1. Demographic Information

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

Male

Female

Name	First	Middle	Last
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Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County
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Country

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

Mailing address (if different from above)

City	State	Zip Code	County
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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

Credential # \_\_\_\_\_ Issue date \_\_\_\_\_

## 2. Other License, Certification, or Registration

(Include previous credentials in Washington State)

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

## 3. Experience

Type of experience of practice and location	Start (mm/yyyy)	End (mm/yyyy)

## 4. AIDS Education and Training Attestation (Check Appropriate Box)

I certify I have completed the minimum of four or 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.**

APPLICANT'S INITIALS

## 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

## 6. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of  
(Print applicant name clearly)

Washington 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 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 \_\_\_\_\_ in \_\_\_\_\_  
(mm/dd/yyyy) (City, state)

By: \_\_\_\_\_  
(Signature of applicant)

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Washington State Department of  
**Health**  
 Veterinary Board of Governors  
 Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360.236.4700

## Out-of-State Credential Verification

**To Applicant:** Complete top portion in full and forward to the state, province, or country in which you hold or have held a credential. There may be a fee for this service.

Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
mm/dd/yyyy

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

License number: \_\_\_\_\_

I authorize the release of the information asked for below to the Washington State Veterinary Board of Governors

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
mm/dd/yyyy

**To State Board:** The above individual is applying for registration as a veterinary Medical Clerk in Washington State. To assist the Board in its review, please complete the following information and return directly to the address shown above. Thank you.

Name of License: \_\_\_\_\_

Credential number: \_\_\_\_\_ Issue date \_\_\_\_\_ Expiration date: \_\_\_\_\_

Issued on the basis of: \_\_\_\_\_

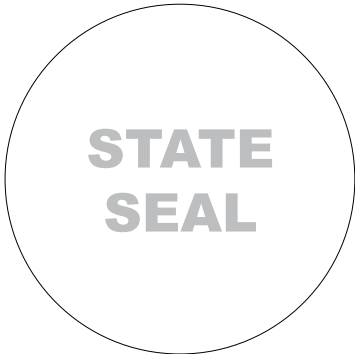
Credential was issued on the basis of: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Has credential ever been suspended, revoked, or subject to other disciplinary action?  Yes  No

If yes, Please explain \_\_\_\_\_

\_\_\_\_\_



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

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

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

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

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

### **RCW/WAC Links**

Uniform Disciplinary Act.....	<a href="#"><u>RCW 18.130</u></a>
Administrative Procedure Act .....	<a href="#"><u>RCW 34.05</u></a>
Administrative procedures and requirements.....	<a href="#"><u>WAC 246-12</u></a>
Veterinary Medicine, Surgery and Dentistry .....	<a href="#"><u>RCW 18.92</u></a>
Veterinary Board of Governors.....	<a href="#"><u>WAC 246-933</u></a>

### **On-Line**

AIDS Training Resources .....	<a href="#"><u>Reference page</u></a>
Veterinary Board of Governors.....	<a href="#"><u>Web page</u></a>