



## **Dentistry Return to Active from Inactive Status (Over Three Years) 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:**

Dental Quality Assurance Commission  
Commission  
PO Box 47877  
Olympia, WA 98504-7877

### **Contact us:**

360-236-4700

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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

You will be notified in writing if further documentation is required.

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

**Active Renewal Fee.** This fee is 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.

**National Provider Identifier Number (NPI):** The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

**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 month, day, and year of your birth.

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

**Address:** List the address we should use to send any information about 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](#).

- 2. Other License, Certification, or Registration.** List in date order, most recent to later, **all** your credentials you have held since last being credentialed in Washington State. Include your last active license in Washington State. Attach additional completed pages if you need more space.
- 3. Training and Experience.** Please list in date order all professional work experience. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. Attach additional 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. 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.

### **Additional Information:**

- Jurisprudence Examination**  
Complete the [on-line examination](#). Print and send your certificate of completion with your application. It is a multiple choice exam and designed to familiarize you with the Washington State dentistry laws. Current laws can be found [here](#).
- Malpractice Clearance**  
Applicants must have malpractice carriers submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted. If coverage is provided via an umbrella policy through a school, or if you are practicing in the military, please indicate in writing.
- Exam Scores**  
A notarized copy of the original Examination Board's (WREB, CRDTS, SRТА, NERB) certificate must be sent. This document verifies passage of the examination, date and location taken, and confirms that no outstanding requirements are owed. Examination results will be accepted for up to five years preceding application to Washington State. Applications for the examination should be requested directly from one of the following:
  - WREB at 602-944-3315
  - CRDTS at 785-273-0380
  - SRТА at 757-428-1003
  - NERB at 301-563-3300 ext. 227.

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Revenue: 0252020000

## Dentistry Return to Active Status from Inactive Status (Over Three Years) License Activation Application

Please type or print clearly. Follow all instructions provided. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name	First	Middle	Last
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Birth date (mm/dd/yyyy)	<b>Place of birth</b>		
	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):

## 2. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. Attach additional completed pages if you need more space.

State	Profession	Credential		Permanent or temporary	License received by		Currently in force
		Year issued	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

## 3. Training and Experience

List in date order all of your professional education and experience including college or university pre-dental program, technical or professional school and practice pertaining to the profession for which you are making application. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. You do not have to list continuing education courses. Attach additional pages if you need more space.

Dates		Name and address of institute, place of practice.	Degree/certificate and date received Type of experience or specialty
From (mm/dd/yyyy)	To (mm/dd/yyyy)		

## 4. AIDS Education and Training Attestation

I certify I have completed the minimum of four 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 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

## 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

## 6. Continuing Education/Continuing Competency Attestation

I certify that I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all classes attended/claimed.

Applicant's Initials	Date

## 7. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of Washington the following is true and correct:  
(Print applicant name clearly)

- 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 \_\_\_\_\_ at \_\_\_\_\_  
(mm/dd/yyyy) (City, state)

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

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Washington State Department of

**Health**

Dental Quality Assurance Commission  
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 above address. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

Name: Last	First	Middle
Mailing Address		
City	State	Zip Code
Any other names used:		
License, Certification, or Registration Number	Date Issued	

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

If you have any questions, please call 360-236-4700.

## (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 license, certification, or registration holder:		
Authority providing verification: (state, name & title)		
Applicant licensed, certified, registered by: Written Examination	Date:	Score:
Name of examination:		
Other Examination	Date:	Score:
Name of examination:		
Is it current? Yes <input type="checkbox"/> No <input type="checkbox"/>	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.		
Have they 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 individual has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

(SEAL)

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

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



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

### **RCW/WAC Links**

[Uniform Disciplinary Act, UDA RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative procedures and requirements, WAC 246-12](#)

[Standard of Professional Conduct Rules, WAC 246-16](#)

[Dental Professionals Laws, RCW 18.260](#)

[Dentistry Rules, WAC 246-817](#)

[Dentistry Laws, RCW 18.32](#)

### **On-Line**

[AIDS Training Resources, Reference Page](#)

[Dental Quality Assurance Commission, Web page](#)

[Drug Enforcement Administration \(DEA\), \[www.deadiversion.usdoj.gov\]\(http://www.deadiversion.usdoj.gov\)](#)

[Washington State Dental Association, \[www.wsda.org/\]\(http://www.wsda.org/\)](#)

[American Dental Association \(ADA\), \[www.ada.org/\]\(http://www.ada.org/\)](#)

### **Listserv**

To receive emails regarding important dental regulation information, please join our interested parties list at, [Listserv](#)

### **Required Continuing Education**

Continuing education (CE) Training after license has been issued, [WAC 246-817-440](#)