



Podiatric Medicine and Surgery Inactive License Activation Application Packet

Contents:

1. 665-026 Contents List/SSN Information/Mailing information 1 page
2. 665-017 Application Instructions Checklist..... 3 pages
3. 665-018 Podiatric Medicine and Surgery Inactive License Activation Application 4 pages
4. 665-009 Hospital Investigative Letter 1 page
5. 665-010 State License Investigative Letter 1 page
6. 665-011 Podiatric Medical Board—Request for Physician Disciplinary Profile/PMLexis Score Report 1 page
7. RCW/WAC and Online Website Links..... 1 page

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 read, complete, and return this [form](#) with your application.

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:

Podiatric Credentialing
P.O. 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 printed clearly in blue or black ink. It is your responsibility to submit the required forms required.

Application 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 the 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. Post Graduate Training:**
Provide in date order, most recent to later, a listing of your post-graduate training. Attach additional completed pages if you need more space. Verify all accredited post graduate training received in the United States. Verification must be completed by the program director with beginning and ending dates and sent directly to this office.
- 3. Professional Experience:**
List in date order, most recent to later, all your professional experience and practice from date of graduation from professional college. Attach additional completed pages if you need more space.
- 4. Hospital Privileges:**
List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five years. Attach additional completed pages if you need more space.
- Verifications must be received directly from each hospital. This does not include post graduate training hospitals.
 - Verification for military hospital privileges may be obtained by the current duty station or, if no longer in active service, National Personnel Records Center, Military Personnel Records, 1 Archives Dr, St Louis MO 63138.
 - Locum Tenens: Hospital privileges of a 30-day or longer duration.
- 5. Other License, Certification, or Registration:**
List in date order, most recent to later, all your credentials to practice medicine in any state or US Territory to include active, inactive, temporary and training credentials. Attach additional completed pages if you need more space.
- 6. 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](#). If AIDS education was included in your professional education or training, an additional course is not required.
- 7. Applicant's Photograph:**
Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and a front view. Your application will not be processed without a current photograph.
- 8. Applicant's Attestation:**
You must sign and date this for us to process the application.

Additional Documentation Required for Activation:

- Continuing Education Attestation.** Required by [WAC 246-12-040](#) and [WAC 246-922-300](#). Include copies of certificates of attendance for the most recent two years, documenting at least 50 hours approved continuing education.
- Professional Liability Action History.** Malpractice information pertaining to any civil suit or judgment in connection with the practice of a health care profession. Include the nature of the case, date and summary of the care given and settlement amount.
The applicant must provide a separate summary of each case and include copies of the settlement or final disposition. If pending, indicate status. If the case is rather old, you should be able to contact the county where it was filed to get the documentation. Please attach on a piece of paper.
- Federation of Podiatric Medical Boards Data Bank Clearance.** The Board requires verification of any disciplinary actions directly from the Federation. Disciplinary reports are \$50.00 per report and may be obtained from:
Federation of Podiatric Medical Boards
12116 Flag Harbor Drive
Germantown, MD 20874-1979
Phone: 202-810-3762
Web Address: <http://www.fpmb.org/>
Email: fpmb@fpmb.org

Date
Stamp
Here

Revenue 0252010000

Podiatric Medicine and Surgery Inactive Credential Activation Application

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

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	National Provider Identifier Number (NPI) (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)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County
------	-------	----------	--------

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 address of record:

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 on file 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):

Podiatric Education

Podiatric school	Medical Specialty	Year of graduation
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2. Podiatric Medical Education and Post Graduate Training

Provide in date order, most recent to later, a listing of your Podiatric educational preparation and post-graduate training. Attach additional completed pages if you need more space.

Schools attended	Number of Years attended	Dates Granted	
		Start mm/yyyy	End mm/yyyy
Podiatric medical education (list all Podiatric schools attended and location)			

Residency Program (list if you have one)

3. Professional Experience

In date order, most recent to later, a list of your professional experience since completion of post-graduate training. Exclude activities listed under other sections. Attach additional completed pages if you need more space.

Name of practice or experience and location	Nature of experience or specialty	From mm/yyyy	To mm/yyyy

4. Hospital Privileges

List hospitals and locations where admitting privileges have been granted within the past five years. Attach additional completed pages if you need more space.

Name of hospital and location (For locum tenens, enter only those of a 30-day or longer duration). See instructions in step 5 of the General Instructions Checklist, Hospital Privileges.	Dates attended	
	From mm/yyyy	To mm/yyyy

5. Previous License

List all licenses to practice Podiatric medicine in any states or US Territories.

State/ territory	Profession	Certificate		Permanent or Temporary	Licensed by		Currently in force
		Year	Number		Exan	Other	
				<input type="checkbox"/> Perm. <input type="checkbox"/> Temp.			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm. <input type="checkbox"/> Temp.			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm. <input type="checkbox"/> Temp.			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm. <input type="checkbox"/> Temp.			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm. <input type="checkbox"/> Temp.			<input type="checkbox"/> No <input type="checkbox"/> Yes

6. Aids Education and Training Attestation

I certify that I have completed a minimum of seven 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 false information, my license may be denied, or if issued suspended or revoked. If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's initials	Today's Date

7. Applicant's Photograph

Photo Here



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 of applicant
5. Instant polaroid photographs **not** acceptable

Height _____

Weight _____

Hair color _____

Color of eyes _____

8. Applicant's Attestation

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

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 have read all laws and rules related to my profession.

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 _____ By: _____
(mm/dd/yyyy) (Original signature of applicant)



Washington State Department of

Health

Podiatric Credentialing

PO Box 47877

Olympia, WA 98504-7877

360-236-4700

Hospital Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
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I have applied for a license to practice podiatric medicine and surgery 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 hospital privileges and return it the address listed above.

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 Podiatric Medical Board.

Signature of Applicant:	Date (mm/dd/yyyy):
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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. Has the applicant ever been asked to resign or surrender any privileges voluntarily in lieu of action being taken?

Yes No If so, for what reason?

4. Is there any information in your files that could call into question the applicant's ability to safely practice Podiatric medicine and surgery? Yes No If yes, explain.

Please attach any copies of information in your records that would provide further information.

Name	Title
Facility	Phone (enter 10 digit #)
Address	
Authorized Signature	Date

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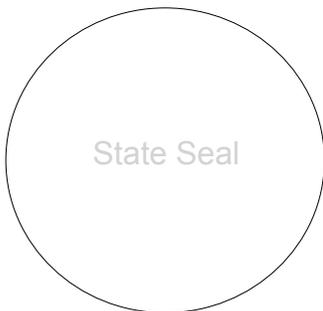


Washington State Department of
Health
 Podiatric Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

State License Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
<p>I have applied for a license to practice podiatric medicine and surgery 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 license and return it the address listed above.</p> <p>Please reply as soon as possible to avoid delays in the licensing process.</p> <p>I hereby authorize you to release the following information to the Washington State Podiatric Medical Board.</p>	
Signature of Applicant:	Date (mm/dd/yyyy):

<p>To assist the Washington State Board in evaluating the above podiatric physician's application, we would appreciate receiving the following information.</p>	
License Number:	Date license was issued:
Status of License: <input type="checkbox"/> Active <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Inactive <input type="checkbox"/> Expired	
Has the applicant's license ever been suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has any other disciplinary or corrective active been taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the licensee surrendered the license in lieu of disciplinary action? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you have answered yes to any of the questions above, attach supporting documentation pertaining to disciplinary orders or any other actions.	



State Board:	
Address:	
Phone (enter 10 digit #):	
Authorized Signature:	Date:

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Washington State Department of

Health

Podiatric Credentialing

PO Box 47877

Olympia, WA 98504-7877

360-236-4700

Podiatric Medical Board

Request for Physician Disciplinary Profile/PMLexis Score Report

This form is to be completed by the podiatric physician and surgeon and mailed directly to the following along with a fee for disciplinary reports plus \$45 fee for PMLexis part III score reports (**exam candidates do not need to request scores**):

Federation of Podiatric Medical Boards

12116 Flag Harbor Drive

Germantown, MD 20874-1979

Phone: 202-810-3762

Beginning March 1, 2004, the Federation of Podiatric Medical Boards will accept orders for PMLexis/Part III score and disciplinary reports via an "order reports" button on its Web site (www.fpmbo.org). After filling out an on-line form, visitors will have the option to immediately pay for requests with their Master Card or Visa credit card.

Name: _____

First

Middle

Last

Address: _____

Street

City

State

Zip

Date of Birth: _____

(mm/dd/yyyy)

Place of birth: _____

(City/state)

Podiatric Medical School: _____

Date of graduation: _____

(mm/dd/yyyy)

Social Security Number: _____

PMLexis Information: State taken: _____

Date taken: _____

(mm/dd/yyyy)

Applicant Signature _____

Date _____

Federation of Podiatric Medical Boards—Please return this form to the address listed above.

PMLexis Part III Score

Disciplinary Report

Federation Stamp

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RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Podiatric Medicine and Surgery Laws, RCW 18.22](#)

[Podiatric Medicine and Surgery Rules, WAC 246-922](#)

Continuing Education

[Podiatric Continuing Medical Education Rules, WAC 246-922-300](#)

[AIDS Training Resources, Reference Page](#)

Online

[Podiatric Medical Board Web page](#)