



## **Veterinary Medication Clerk Expired Registration Activation Application Packet**

### **Contents:**

1. 672-097 ..... Contents List/SSN Information/Mailing Information.....1 page
2. 672-063 ..... Application Instructions Checklist .....2 pages
3. 672-062 ..... Veterinary Medication Clerk Expired Registration Application...3 pages
4. 672-095 ..... Out-of-State Credential Verification .....2 pages
5. 672-079 ..... Transfer of Sponsoring Veterinarian .....2 pages
6. 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 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

(This page intentionally left blank.)

## 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](#). If AIDS education was included in your professional education or training, an additional course is not required.
- 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.

**Additional Information:**

- Complete the [Transfer of Sponsoring Veterinarian form](#) and submit it with your license application.

Date  
Stamp  
Here

Revenue 0283040000

## Veterinary Medication Clerk Expired Registration 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)

Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)	<b>Place of birth</b>		
	City	State	Country

Address

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

Country

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

Email address

Mailing address if different from above address of record

City	State	Zip Code	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 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):

## 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.** If AIDS education was included in your professional education or training, an additional course is not required.

APPLICANT'S INITIALS

TODAY'S 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

--

## 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 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 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)

(This page intentionally left blank.)



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:**

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 above. 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:



Veterinary Board of Governors  
Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877  
360-236-4700

## Veterinary Medication Clerk Registration Transfer of Sponsoring Veterinarian

Please Type or Print in blue or black Ink

<b>Veterinary Medication Clerk</b>			
Veterinary Medication Clerk's name			
Mailing address			
City	State	Zip Code	County
Phone during normal business hours (enter 10 digit #)		Residence Phone (enter 10 digit #)	
Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	
Have you ever been known by any other name? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list			
<b>Previous Sponsoring Veterinarian</b>			
Previous Sponsoring Veterinarian's Name			
Previous Sponsoring Practice/Clinic Name			
Practice/Clinic address			
City	State	Zip Code	County
Practice/Clinic Phone (enter 10 digit #)		Date terminating employment with previous sponsoring veterinarian	
<b>New Sponsoring Veterinarian</b>			
New Sponsoring Veterinarian's Name			
Sponsoring Practice/Clinic Name			
Practice/Clinic address			
City	State	Zip Code	County
Practice/Clinic Phone (enter 10 digit #)		Date employment begins with sponsoring veterinarian	

**Submit this form to the address listed above.**

## **Sponsoring Veterinarian Signature**

I, the undersigned, attest that I am the person described and identified as the New Sponsoring Veterinarian in this Application for Transfer of Sponsoring Veterinarian Registration in the State of Washington. I attest I will be supervising the training/employment of the above named Veterinary Clerk according to the Veterinary Medication Clerk Model Training Program which was adopted by the Veterinary Board of Governors on November 1, 1993.

I affirm that Class I, II, III, IV, or V controlled substances are not included in, and are specifically excluded from, any duties that a registered Veterinary Medication Clerk may perform.

I understand that the Department may require additional information from me, and that if I provide false or incomplete information the Application for Transfer may be denied, or the registration of the Veterinary Medication Clerk ultimately suspended or revoked.

---

Signature of Sponsoring Veterinarian

---

Date (mm/dd/yyyy)



## **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](#)

[Veterinary Medicine, Surgery and Dentistry, RCW 18.92](#)

[Veterinary Board of Governors, WAC 246-933](#)

### **On-Line**

[AIDS Training Resources, Reference page](#)

[Veterinary Board of Governors, Web page](#)