Washington State Department of Health

Cardiovascular Invasive Specialist Expired 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:

Cardiovascular Invasive Specialist Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Washington State Department of Health

Application Instructions Checklist

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:

- ☐ **Pay** Late Renewal Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Pay** Expired Certification Activation 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.

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 certification. 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 credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. Attach additional pages if you need more space.

☐ **3. Experience:**
In date order, most recent to later, list all your professional work experience since your Washington State credential expired. Attach additional 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.

Additonal Information:

If you obtained your credential through the **Alternate Certification Process—Time Limited** and that credential has been expired for more than one year, you must now meet the education and examination requirements under **WAC 246-926-410** before being issued a new certification. This requirement is established by law under **RCW 18.84.085(2)**.

If you obtained your credential based on **approved education and examination requirements**, you may proceed with reactivation of your certification using this application form.

Washington State Department of Health

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Cardiovascular Invasive Specialist Expired Certification 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)	☐ Male ☐ Female

Name	First	Middle	Last

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 #)
Email address		
Mailing address (if different from above)		

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 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

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

I certify I have completed the 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 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

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
(Print applicant name clearly)
the state of 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 _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Washington State Department of Health
Cardiovascualr Invasive
Specialist Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of this form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. The regulatory agency will complete page two.

Name: Last	First	Middle
Mailing Address		
City	State	Zip Code
Phone (enter 10 digit #)	Cell (enter 10 digit #)	
Email address		
Any other names used:		
Type of license(s) you hold or have held in other state(s):		
Washington State healthcare credential type you are applying for:		
Washington State healthcare credential number (if available):	Date Issued	

Have the licensing agency complete page two and return this form to the address listed above.

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

This form may be duplicated.

(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)		
Type of healthcare license, certification or registration:		
Healthcare license, certification or registration number:		
Applicant was credentialed by: ☐ Written Examination	Date:	Score:
☐ Other Examination	Date:	Score:
Name of examination:		
☐ Endorsement		
☐ Not applicable (please explain):		
Is credential current: ☐ Yes ☐ No Expiration Date:	Original Issuance Date:	
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no," please attach explanation.		
Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ 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? ☐ Yes ☐ No		

(SEAL)

Signature:

Title:

Date:

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Washington State Department of Health

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

Cardiovascular Invasive Specialist Laws, RCW 18.84

Cardiovascular Invasive Specialist Rules, WAC 246-926

Alternative Training Requirements, WAC 246-926-110

Online

Cardiovascular Invasive Specialist Program Web Page

AIDS Training Resources Reference Page