Podiatric Medicine and Surgery Inactive License Activation Application Packet

Contents:

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

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

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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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. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. 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.

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 completes 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 all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

☐ **6. 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.

☐ **7. 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**

Washington State Department of Health

Date Stamp Here

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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)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name: First Middle Last

Birth date (mm/dd/yyyy)

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):

Podiatric Education

Podiatric school	Medical Specialty	Year of graduation

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	
				☐ Perm. ☐ Temp.			☐ No ☐ Yes
				☐ Perm. ☐ Temp.			☐ No ☐ Yes
				☐ Perm. ☐ Temp.			☐ No ☐ Yes
				☐ Perm. ☐ Temp.			☐ No ☐ Yes
				☐ Perm. ☐ Temp.			☐ No ☐ Yes

6. 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 _____

7. 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):

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):

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
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.fpmb.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

Online

Podiatric Medical Board Web Page