Podiatric Physician and Surgeon License 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 forms required.

☐ **Application Fee**. This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **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, date, 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. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Post Graduate Training:**

List in date order, most recent to later, 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.

☐ **4. 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.

☐ **5. 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.

☐ **6. 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.

☐ **7. Applicant's Attestation:**

You must sign and date this for us to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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Licensing Requirements

Requirements for License

1. Graduated from a legally incorporated, regularly established school of podiatry approved by the Podiatric Medical Board.
2. Satisfactorily completed one year of postgraduate podiatric medical training.
    a. Programs approved by the American Podiatric Medical Association Council on Podiatric Medical Education which are listed in the 1992-1993 directory of Approved Residencies in Podiatric Medicine, or programs approved by the Council on Podiatric Medical Education when post graduate training is obtained.
    b. Applicants graduating before July 1, 1993, are exempt from the postgraduate training requirement.
3. Applicants must pass Part I and Part II of the National Board Examination prepared by the National Board of Podiatric Examiners.
4. Pass the PMLexis (Part III) examination. Scores from the PMLexis taken in another state are acceptable if taken on or after June, 1988.

Required Documents

- Official transcripts from the college where you obtained your podiatric degree.
- Part I, II & III (PMLexis) and Disciplinary reports should be ordered directly from the Federation of Podiatric Medical Boards via their online system at https://www.fpmb.org. Payment can be made with a credit card. Alternatively, online orders can be printed and mailed to the FPMB with a check.
- Verification of all accredited postgraduate podiatric medical training from the program director of each training program. Verifications must include the beginning and ending dates of the training. Copies of evaluations, or a summary of the applicant's performance, may accompany the completed form.
- Verifications of all podiatric licenses whether active or inactive, including training licenses. Some states require a fee for processing verification letters. Please check with each state to determine the fee.
- Verification letters sent directly to the board from all hospitals where hospital privileges were held in the last five years. Do not include the hospitals during your postgraduate training.

Limited License

A limited license may be issued to an individual who is participating in a post graduate training program in Washington State.

Applicants without previous postgraduate training must submit:

1. Official transcripts from the college where podiatric degree was obtained.
2. Limited License Verification Postgraduate Training letter from the accredited podiatric postgraduate medical training program you are entering in Washington State.
3. If you have previous postgraduate training or meet any of the other criteria described in the required documents section, send the applicable documents.

Limited licenses are issued for a one year period beginning with the date of entry into the training program. Limited licenses are renewable annually.

Temporary Permits

A temporary permit to practice podiatric medicine and surgery may be issued to an individual in another state that has equivalent licensing standards to those in Washington. This license is only for those applying for full license.

- Documentation from the reciprocal state that the licensing standards used for issuing the license are equivalent to the Washington licensing standards.
- Verification of all state licenses, whether active or inactive, indicating that the applicant is not subject to charges or disciplinary action for unprofessional conduct or impairment.
- Verification from the Federation of State Podiatric Medical Board's disciplinary action data bank that the applicant has not been disciplined by a state board or federal agency.

The temporary permit shall be issued for 60 days after which time it will become invalid. The temporary permit shall be returned to the Department of Health upon expiration or receipt of a full license. A temporary permit shall be issued only once to each applicant.

Note: Because verification from the reciprocal state that standards for license are substantially equivalent to Washington standards is required, the temporary license process may not be as expeditious as obtaining full license.

Washington State Department of Health

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Revenue 0252090000

Podiatric Physician and Surgeon License Application

Application for (check one): ☐ National Board/PMLexis Endorsement ☐ Temporary License

☐ Limited License Postgraduate Program_____

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

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. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? ☐ ☐
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? ☐ ☐
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application? ☐ ☐
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? ☐ ☐
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

3. Podiatric Medical Education and Post Graduate Training

In date order, list your Podiatric educational preparation and post-graduate training. Attach additional 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)			

4. Professional Experience

List in date order all your professional experience since completion of post-graduate training. Exclude activities listed under other sections. Attach additional pages if you need more space.

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

5. Hospital Privileges

List hospitals and locations where admitting privileges have been granted within the past five years. Attach additional 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

6. 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		Exam	Other	
				☐ Perm. ☐ Temp.			☐ No ☐ Yes
				☐ Perm. ☐ Temp.			☐ No ☐ Yes
				☐ Perm. ☐ Temp.			☐ No ☐ Yes
				☐ Perm. ☐ Temp.			☐ No ☐ Yes
				☐ Perm. ☐ Temp.			☐ No ☐ Yes

7. Applicant's Attestation

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

Postgraduate Training 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 postgraduate training 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. Is the applicant currently or has the applicant ever been engaged in postgraduate training in your program? ☐ Yes ☐ No Beginning Date: Ending Date:	
2. Briefly evaluate the applicant's competence and conduct during the program:	
3. Has the program ever had cause to restrict, suspend or terminate, or ask for a voluntary resignation of the applicant's participation in the program? ☐ Yes ☐ No If yes, explain and include performance evaluations.	
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.	

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

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
Limited License Postgraduate Training Verification

This is to certify that _____ has been
Name of Podiatric Physician

accepted in a postgraduate training program in _____
Service

at _____ for the period beginning
Institution

_____. The individual responsible for this resident's patient
Start date

care activities will be _____
Director of program (print name)

_____
Program address

_____
Signature

* A resident podiatric physician means an individual who has graduated from an approved school of podiatric medicine and is serving a period of postgraduate clinical training sponsored by a college or university in this state or by a hospital accredited in this state whose program is approved by the American Podiatric Medical Association Council on podiatric medical education at the time of training. Postgraduate clinical training includes rotating podiatric residency, podiatric orthopedic residency and podiatric surgical residency.

Return completed form to the address above.

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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