WASHINGTON MEDICAL COMMISSION
P.O. Box 47866 | Olympia, WA 98504-7866
360-236-2750 | Medical.Commission@doh.wa.gov

Please Note:

To apply for a physician medical license, (MD), please print pages 1 – 23.

To apply for a physician assistant license, please print pages 24 - 38

Washington Medical Commission
P.O. Box 47866 | Olympia, WA 98504-7866
360-236-2750 | Medical.Commission@wmc.wa.gov

Dear Applicant:

The Washington Medical Commission is pleased you have chosen to apply for licensure in Washington. This application is for allopathic medical school graduates only. Osteopathic physicians should complete the application for the Washington Board of Osteopathic Medicine and Surgery.

Prior to applying for license, please read through carefully and consider all the following laws on applications:

- RCW 18.130.180 defines unprofessional conduct for any license holder or applicant. RCW 18.130.170 covers the inability to practice with reasonable skill and safety by reason of a mental or physical condition.
- An application for a license may not be withdrawn after the Commission or the reviewing commission member determines that grounds exist for denial of the license or for the issuance of a conditional license.

Medical Commission licensing links to applications, forms, requirements, renewals, fees, and other items are located at: https://wmc.wa.gov/licensing

After the application and fees have been received by the Department of Health, you will be notified if any documents or data are missing. **It is very important that you allow a minimum of sixteen to twenty weeks to process your application.** Only complete applications will be considered for review. Routine applications require five days for processing. Non-routine applications require more time for processing. All information, documents, data, etc. provided to the department by the applicant will become part of the file.

Note: It is the responsibility of the applicant to submit the correct forms to the appropriate entities to obtain verification information in support of the application for physician license. Documents submitted in support of the application must be submitted directly from the originating source. Copies of transcripts post graduate certificates, licenses, hospital privileges, and examination scores, will not be accepted.

Applications that are pending for one year will become invalid, along with the fee and any other supporting documentation. After that time, it will be necessary to begin the process over with a new application, current fee, and all supporting documents.

A temporary permit can be issued if the applicant:

- Has been previously licensed from a recognized jurisdiction (listed on page 6 of the Addendum to Application, Forms and Affidavit Section of the Online UA).

If an applicant has not practiced clinical medicine for two or more years, the Commission may require the applicant to do one of more of the following:

- Pass the Federation of State Medical Boards Special Purpose Examination (SPEX). You can contact them at 817.868.4000 or visit their website at https://www.fsmb.org/transcripts/.
- Undergo a knowledge and skills assessment at The Center for Personalized Education for Physicians (CPEP) You can contact them at 303.750.7150 or www.cpepdoc.org.
- Undergo a knowledge and skills assessment at the University of California at San Diego School of Medicine, Physician Assessment and Clinical Education Program (PACE). You can contact them at 619.543.6770 or http://www.paceprogram.ucsd.edu/.
- Successfully complete an additional year or more of post graduate training, accredited through the Accreditation Council for Graduate Medical Education, and pre-approved by the Commission.
- Complete any other examination or assessment the Commission deems appropriate.

Once the Commission requests an applicant to complete one of these requirements, the Commission will not permit the applicant to withdraw the application. If the applicant does not successfully comply with the Commission's request to complete one of the above items, the Commission may deny the application.

The Commission cannot refund application fees. WAC 246-12-340.

Certification Requirements

Post Graduate Training Requirements:

- If you are graduated from a medical school before July 28, 1985, one year of post graduate training in the United States or Canada is required, or
- After July 28, 1985, two years of post-graduate training in the United States or Canada are required.

Examination Requirements:

- Any applicant graduating from medical school after October 11, 1993 must take and pass all steps of the United States Medical License Examination (USMLE) or the Licentiate of the Medical Council of Canada (LMCC).
- Any applicant graduating from medical school before October 11, 1993 and using a state or territory license examination as their qualifying examination will be considered on a case-by-case basis. These applicants are also required to obtain the Examination and Board Action History Report (EBAHR) sent directly from FSMB by ordering online at https://www.fsmb.org/transcripts/ or by calling 817.868.4000. If you are using FCVS to verify your credentials, they will obtain this information on your behalf.

Certification is not required if the applicant was issued a physician license in the United States prior to 1958 or completed a Fifth Pathway program.

There are five (5) pathways:

1. Graduation from a U.S. medical school
2. Certification by the ECFMG – Education Commission for Foreign Medical Graduates
3. Full and unrestricted licensure by a U.S. licensing jurisdiction
4. Passing the Spanish language licensing examination in Puerto Rico
5. Fifth Pathway program – 1971 to 2009

Additional Information

For spouses and registered domestic 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.

WAC 246-12-020 (3) How to obtain an initial credential. The initial credential will expire on the practitioner's birthday. Initial credentials issued within ninety days of the practitioner's birthday do not expire until the practitioner's next birthday.

WAC 246-12-310 Address changes. It is the responsibility of each practitioner to maintain his or her current address on file with the department. Requests for address changes may be made either by telephone or in writing. The mailing address on file with the department will be used for mailing of all official matters to the practitioner.

WAC 246-919-990 Physician and surgeon fees and renewal cycle. Licenses must be renewed every two years on the practitioner's birthday.

AMA and FSMB Profiles. The department staff will obtain the American Medical Association (AMA) Physician profile report and the Federation of State Medical Boards (FSMB) data bank clearance report. However, if staff is unable to obtain the reports electronically, the applicant will be required to submit requests and pay any applicable fees.

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.

The Federation Credentials Verification Service (FCVS)

The Board **highly recommends**, but does not require, the use of the Federation Credentials Verification Service (FCVS) for credentials verification as part of the licensure process. FCVS verifies primary source documents related to your identity, education, training, and more, and then creates a personalized profile that eliminates the re-verification of items that never change. The FCVS profile can be updated as needed throughout your career, resulting in a shortened credentialing process when applying to more than one state board.

To work on the FCVS application (credentials verification only), visit http://www.fsmb.org/fcvs/ and select FCVS in the Licensure or Sign In menu, then sign in and continue as directed. Complete an Initial Application if this is your first time using FCVS. Complete a Subsequent Application to update your existing profile. All applicants must designate the Board to receive the profile. Self-designations will not be accepted.

Applicants not using FCVS must provide their credentials directly to the Board for verification. **Applicants using FCVS to verify their credentials are still required to complete the Online Washington State Medical Commission Licensure Application (UA) for licensure.**

For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

The Uniform Application for Physician State Licensure (UA)

The Board uses the Uniform Application for Physician State Licensure (UA) as part of its licensure process. After completing the UA for the first time, your application is securely stored and can be sent to another participating board as long as the state-specific requirements are also completed for each board. Updates to the UA can be made as needed.

You will be asked to account for all time since medical school graduation, including employment and non-working activities plus information on malpractice claims, if applicable. We recommend having this information on hand before you begin your UA. Failure to submit all required information and documentation will result in processing delays. Use the checklist at the end of these instructions to ensure that you submit all necessary documentation.

To work on the Uniform Application, visit https://www.fsmb.org/uniform-application/ and select Uniform Application in the Licensure or Sign In menu, then sign in as directed. Complete as directed on each page. If you have submitted a UA previously, select the board in the State Board section to open the UA for editing. Submit your UA to the board when you have finished updating your UA.

Please note the following:

- "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 your application may be denied.

- Indicate whether you are known or have been known under any other name(s) in the Alternate Name section. 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.

- Provide both your current home address and current business practice/training address, otherwise an error will occur. Do not enter the same address for both home and work.

The Board Mailing selection indicates the address we should use to send any information on your credential. Be sure to include the city, state, zip code, and country. 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 of Health. See WAC 246-12-310.

The current address and telephone number of a health care provider governed under chapter 18.130 RCW is not public 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 submit this application, you must complete Addendum 7 Social Security Number Notification form (located in the Addendum part of the Forms & Affidavit screen within the UA). A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

- You will be unable to edit MD and DO licenses in the UA as all MD and DO license information comes directly into the system from the state boards. If changes are needed, email ua@fsmb.org with the correct information.

  Enter all other professional licenses (nurse, EMT, physician assistant, etc.) you have held (active or inactive) in the U.S. or Canada. Request verification of your license from these boards by using the UA Licensure Verification Form in this packet.

  If you are applying for a special or temporary license and/or hold licenses in countries outside the U.S. or Canada, provide that information on a separate sheet of paper.

- On the Chronology of Activities page, list ALL activities (medical, non-medical, and post graduate training not already listed) in chronological order beginning with medical school graduation to the present date. **Identify any period of time breaks of 30 days or more.** Include hospitals, teaching institutions, HMOs, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. If you have worked in a number of facilities under locum tenens or while in the military, please list each location separately. Include all periods of unemployment.

  Check the "Staff Privileges" box for all locations where you have had admitting privileges.

  Clinical time indicates time spent with patients. Administrative indicates time spent on paperwork or research.

- Report ALL past and/or current professional liability claims or lawsuits which have been filed against you. You must submit a copy of final disposition of each case, including dismissals. You may leave this page blank if you have no malpractice liability claims.

In addition to completing the core UA online, all applicants must:

- Complete the addenda in this packet as instructed.

- Submit a UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent directly to the Board. Attach a recent (less than 6 months old) two inch by two-inch (2" x 2") passport quality, color photograph of yourself (head and shoulders only) to the form in the space provided. Proof photos, negatives, and digital photos are not acceptable. Sign the photograph in ink across the lower portion of its front side. This form must be notarized and sent to the Washington State Medical Commission.

- Have each full, temporary, training, or limited healthcare or profession license or certification you have ever held in the U.S. or Canada verified by the granting board, whether the license or certification is active or inactive. Determine the fees and verification method for each board using the licensure verification resource at https://www.fsmb.org/uniform-application/. Use the UA Licensure Verification Form for boards that need a written request. If the verifying board uses VeriDoc or another method, use that method instead.

If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education Verification, Postgraduate Training Verification, or Fifth Pathway Verification forms. Do not send any identity documents, transcripts, certificates, or examination scores to the Board. FCVS handles all of this for you.

- **If you are not using FCVS for credentials verification,**

- Contact each appropriate exam entity to have a certified transcript of your scores sent directly to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript from the NBME. For contact information, see the UA FAQ at https://www.fsmb.org/uniform-application/ua-faq/.
- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms in this packet as directed on each form. If transcripts from your medical school are not in English, an original, certified, and official English translation is required.

- **International Medical Graduates:** In addition to the standard requirements previously stated, international medical graduates not using FCVS must also submit one of the following:

    - **Educational Commission for Foreign Medical Graduates (ECFMG) Verification** (International Medical Graduates Only). Certification must be sent directly from the ECFMG to this office stating that the applicant has been issued a standard certificate with an indefinite status, pursuant to **WAC 246-919-340.** Log on to https://cvsonline2.ecfmg.org/ for the request form or to submit the request online. Confirmations are sent directly to the Board. For questions or assistance, call 215-386-5900 or email info@ecfmg.org.

    - **Fifth Pathway**: The AMA defines a *pathway* as an approved avenue to residency training at a U.S. hospital that completes a medical student's education. Fifth Pathway applicants must submit evidence of successful completion of an accredited Fifth Pathway Program (see UA Fifth Pathway verification form in this packet).

For UA assistance, see the UA FAQ at https://www.fsmb.org/uniform-application/ua-faq/. If your issue is not listed, contact UA customer service at 800-793-7939 or ua@fsmb.org with a description of the problem and your username or Federation ID number. Email a screenshot if you see an error.

Please use the checklist on the next page to ensure that you submit all needed items.

Health Professions Reference Numbers and Links

Uniform Disciplinary Act, UDA RCW 18.130 http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130

Administrative Procedure Act, APA RCW 34.05 http://apps.leg.wa.gov/RCW/default.aspx?cite=34.05

Administrative Procedures and Requirements, WAC 246-12 http://apps.leg.wa.gov/WAC/default.aspx?cite=246-12

Washington Medical Commission https://wmc.wa.gov/licensing

If you have any questions, please email the Commission at medical.commission@wmc.wa.gov

UNIFORM APPLICATION CHECKLIST

After completing the online Uniform Application, you are responsible for submitting certain documents. There are two different checklists below; one if you are using the Federation Credentials Verification Service (FCVS) and one if you are not using FCVS. Please use the checklist that applies to you.

	NOT using FCVS	Using FCVS
Completed and submitted the online application (UA).	☐	☐
Completed State Addendum, all documentation, and check or money order for non-refundable application fee sent to the Board.	☐	☐
UA Affidavit and Authorization for Release of Information form sent to the Board.	☐	☐
Final disposition documentation for each malpractice claim and/or lawsuit sent to the Board.	☐	☐
Associate Professor or Higher Verification Form.	☐	☐
Licensure verification sent to the Board from all boards through which you have ever held any healthcare license. Use the UA Licensure Verification Form in this packet as needed.	☐	☐
Supporting documentation of any legal name change sent to the Board.	☐	Completed via FCVS
Medical Education Verification form sent to the Board from all medical schools attended – include a copy of your diploma (must be sealed by your school).	☐	Completed via FCVS
Medical School Transcripts sent to the Board by your medical school(s).	☐	Completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended.	☐	Completed via FCVS
A copy of your postgraduate training certificate(s) sent to the Board.	☐	Completed via FCVS
Fifth Pathway Verification form (if applicable) sent to the Board.	☐	Completed via FCVS
Examination Transcripts sent to the Board.	☐	Completed via FCVS
ECFMG Status Report (if applicable) sent to the Board.	☐	Completed via FCVS

Washington Medical Commission
P.O. Box 47866 | Olympia, WA 98504-7866
360-236-2750 | Medical.Commission@wmc.wa.gov

Addendum to Application

Addendum 1 – Licensure Application Fee Payment Form. Please send your application fee along with this form to the Board immediately upon submission of your application. Please note that your application will not be processed until we receive your application fee.

Addendum 2 – Questions 1-15. 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 questions. 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.
- "Another jurisdiction" means any other country, state, federal territory, or military authority.

Addendum 3 – Temporary Permit Request. A temporary permit can be issued if you:

- Have been previously licensed from a recognized jurisdiction (listed on page 2 of addendum 3).

Addendum 4 and 4A – Hospital Privileges. (Excluding post graduate training) List all hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. Verifications must be received directly from each hospital. Please send the Hospital Privilege Verification Form (Addendum 5A) to each hospital.

Addendum 5 – Applicant's Attestation and Photograph. You must sign and date this form for the Commission to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Attach a current photograph of yourself in the box provided or attach to the application. Indicate the date the photograph was taken. Sign in ink across the bottom of the photo. The photo must be clear, close up, and front view.

Addendum 6 – Social Security Number Notification. If you do not have a social security number at the time you submit this application, you must complete the Social Security Number Notification form and return it to the Commission.

Associate Professor or Higher Verification Form: Complete the Associate Professor or Higher Verification if you are an applicant who currently has a Teaching/Research limited license in the state of Washington. Please complete the top section of this form and have the Dean of a Washington accredited school of medicine or Chief Executive (Medical) Officer of a licensed health care facility in the state of Washington complete the bottom portion verifying that you have continuously held the position of associate professor or higher for at least three years.

Mail all payments and addenda forms to:
The Department of Health
PO Box 1099
Olympia, WA 98507-1099

All verification forms should be returned to the following address by the verifying entity:
Washington Medical Commission
Attn: MD Credentialing Unit
PO Box 47866
Olympia WA 98504-7866
Medical.commission@wmc.wa.gov

Addendum 1 – Licensure Application Fee Payment Form

Please use the licensure fee schedule below to determine the current fees for licensure **(this fee is non-refundable)**. You may pay the required fee by check or money order made payable to the Washington Department of Health. Please send your application fee along with this form to the Board immediately upon submission of your application. Please note that your application will not be processed until we receive your application fee.

Please complete the following information:

Last Name, First Name, and Middle Initial _____ FCVS Profile # (if applicable) _____

Email Address _____ Home Phone _____ Alternate # _____

Mailing Address _____

City _____ State _____ Zip _____

Payment Type:

Check ☐ Check No. _____ Amount: _____

Money Order ☐ Money Order No. _____ Amount: _____

Mail Payment & Payment Form to:
The Department of Health
PO Box 1099
Olympia, WA 98507-1099

Type of Non-Refundable Fee	Fee Amount
Physician and Surgeon (MD)	
Application	$491.00 *
Duplicate license	$15.00
Temporary permit	$50.00
Application fee (transitioning from a postgraduate training limited license)	$166.00
Postgraduate Limited License (RCW 18.71.095):	
Limited license application	$391.00 *
Limited license renewal	$391.00 *
Limited duplicate license	$15.00
Physician Assistant (PA)	
Application	$116.00 *
Duplicate license	$15.00

For current renewal fees please see the Washington Medical Commission website: https://wmc.wa.gov/licensing/fees

* Includes fee to access the University of Washington (UW) HEAL-WA web site that 2007 legislation requires and the annual $16.00 Washington Physician Health Program surcharge.

The surcharge is assessed at $50.00 on each application and for each year of the renewal period as required in RCW 18.71.310(2) (e.g., a 2-year renewal fee includes $100.00 for the surcharge).

Addendum 2 – Personal Data Questions

Please answer the questions below. If an explanation is asked for, please provide on a separate sheet.

		YES	NO
1.	Do you have a medical condition which in any way currently impairs or limits your ability to practice your profession with reasonable skill and safety? **If yes, please attach any supporting documentation and a detailed explanation.** **"Medical Condition"** includes physiological, medical, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, sleep disorder, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.' You may answer No of the behavior or condition is already known to the Washington Physician Health Program (WPHP). "Known to WPHP" means that you have informed WPHP of your behavior or condition and are complying with all WPHP's requirements for evaluation, treatment, and/or monitoring. **If Yes**, you must submit detailed information to the Commission that will allow the Commission to assess your ability to practice safely, completely, and without impairment to your professional judgement, skill, or knowledge. In addition to this information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Commission. **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 six months. **"Chemical substances"** include alcohol, drugs, or medications, whether taken legally or illegally. Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgements, decisions, orders agreements and surrenders. The department does criminal background checks on all applicants.	☐	☐
3.	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 3, 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.** **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.**	☐	☐

Addendum 2 – Personal Data Questions (Cont.)

	YES	NO
4. 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?	☐	☐
5. 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 judgements, decisions, and agreements?	☐	☐
6. 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?	☐	☐
7. Have you ever been surrendered a credential like those listed in number 6, in connection with or to avoid action by a state, federal or foreign authority?	☐	☐
8. Have you ever been named in any civil suit or suffered any civil judgement for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
9. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☐
10. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☐
11. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☐
12. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☐
13. Have you ever been disqualified from working with vulnerable person by the Department of Social and Health Services (DSHS)?	☐	☐

Washington State Department of Health

Addendum 3 – Temporary Permit Request

I hereby request a **one time only temporary permit**. I understand that the temporary permit shall expire upon the issuance of a full license, initiation of an investigation by the commission, or 90 days, whichever occurs first.

Signature _____ Date _____

Print or type full name _____ Date of birth _____

Mailing address _____

City _____ State _____ Zip Code _____

Note: Fees submitted with application for initial credentialing, examinations, renewal, and other fees associated with the licensing and regulation of the profession are non-refundable. See WAC 246-12-340.

General Information

Must be licensed in a recognized jurisdiction. See list on page two.

A temporary permit may be issued upon receipt of the following:

1. Completed application form.
   a. If any personal data questions 1-13 have a positive answer, it has to be reviewed by the commission's designee.
2. Temporary permit request form.
3. Application and temporary permit fees paid.
4. A clear Federation of State Medical Boards (FSMB) data bank clearance report.
5. A clear American Medical Association Profile.
6. Written verification from ALL states in which the applicant was or is licensed.

For Office use only

☐ Approved

☐ Disapproved

Review date _____

Signature _____

General Information on Recognized Jurisdictions

Jurisdictions with licensing standards substantially the same as Washington's standards, for postgraduate training requirements are set out below.

If you are a US/Canadian physician who graduated after July 28, 1985 (requirement of 2 years of postgraduate medical training), you must have a license in one of the following states:

Alaska	Maine	New Hampshire	Rhode Island
Connecticut	Michigan	New Jersey	South Dakota
Illinois	Montana	New Mexico	Utah
Kentucky	Nevada	Pennsylvania	

If you are a US/Canadian physician who graduated before July 28, 1985 (requirement of 1 year of postgraduate medical training), you must have a license in one of the following states:

Alabama	Idaho	Missouri	Pennsylvania
Alaska	Illinois	Montana	Rhode Island
Arizona	Indiana	Nebraska	South Carolina
Arkansas	Iowa	Nevada	South Dakota
California	Kansas	New Hampshire	Texas
Colorado	Kentucky	New Jersey	Utah
Connecticut	Louisiana	New Mexico	Vermont
Delaware	Maine	New York	Virginia
District of Columbia	Maryland	North Carolina	West Virginia
Florida	Massachusetts	North Dakota	Wisconsin
Georgia	Michigan	Ohio	Wyoming
Guam	Minnesota	Oklahoma	
Hawaii	Mississippi	Oregon	

If you are a foreign medical graduate who graduated after July 28, 1985 (requirement of 2 years of postgraduate medical training and ECFMG certification), you must have a license in one of the following states:

Arizona	Kentucky	Montana	Ohio
Colorado	Louisiana	Nebraska	Oregon
Connecticut	Maine	Nevada	Rhode Island
Delaware	Maryland	New Hampshire	Tennessee
Georgia	Massachusetts	New Jersey	Texas
Hawaii	Michigan	New Mexico	Virginia
Idaho	Minnesota	New York	West Virginia
Indiana	Mississippi	North Carolina	Wyoming
Kansas	Missouri	North Dakota	

If you are a foreign medical graduate who graduated before July 28, 1985 (requirement of 1 year of postgraduate medical training and ECFMG certification), you must have a license in one of the following states:

Alabama	Idaho	Missouri	Pennsylvania
Alaska	Illinois	Montana	Rhode Island
Arizona	Indiana	Nebraska	South Carolina
Arkansas	Iowa	Nevada	South Dakota
California	Kansas	New Hampshire	Tennessee
Colorado	Kentucky	New Jersey	Texas
Connecticut	Louisiana	New Mexico	Utah
Delaware	Maine	New York	Vermont
District of Columbia	Maryland	North Carolina	Virginia
Florida	Massachusetts	North Dakota	West Virginia
Georgia	Michigan	Ohio	Wisconsin
Guam	Minnesota	Oklahoma	Wyoming
Hawaii	Mississippi	Oregon	

Addendum 4 – Hospital Privileges

Hospital Privileges: (*Excluding Post Graduate Training*) List all hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. If you need additional space, please attach a separate piece of paper.

- Verifications must be received directly from each hospital. Please send the Hospital Privilege Verification Form (Addendum 4A) to 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, the Human Resource Command, 1 Reserve Way, St. Louis, MO 63132.
- Locum Tenens: Hospital privileges of a 30-day or longer duration.

	Dates Attended	
Name of Hospital	**Start Date (mm/dd/yyyy)**	**End Date (mm/dd/yyyy)**

_____

Print or type full name

Addendum 4a – Hospital Privilege Verification Form

This section to be completed by the applicant:

To: Hospital Administration (Excluding post-graduate training hospital privileges)

Hospital Name: _____

Address: _____

RE: Verification and evaluation of privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

Applicant name _____ Birth date _____
Print or type mm/dd/yyyy

Signature of applicant _____

This section to be completed by the hospital:

1. _____ has/had admitting or specialty privileges at this hospital from _____ to _____.
   mm/yyyy mm/yyyy
2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration? ☐ Yes ☐ No
   If yes, please explain _____
   _____
   _____
3. Has the applicant ever been asked to resign? ☐ Yes ☐ No If yes, please explain _____
   _____
   _____
4. Did the applicant ever resign in lieu of or to avoid adverse action? ☐ Yes ☐ No
5. Has a report concerning the applicant ever been sent to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank? ☐ Yes ☐ No

Return to: Washington Medical Commission • PO Box 47866 • Olympia, WA 98504-7866
medical.commission@wmc.wa.gov

Seal

Signature _____

Title _____
Please type or print

Hospital _____

Address _____

_____

Date _____ Phone _____

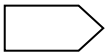
Addendum 5 – Applicant's Attestations and Photograph

Medical Specialty: _____

AIDS Education and Training Attestation

AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by WAC 246-12-290. Course content can be found at WAC 246-12-270.

I certify that I have completed the minimum of four 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.

Photo Here 

Attach Current Photograph here.
Indicate Date Taken and Sign in Ink Across the Bottom of the Photo.

Note: Photograph **Must** be:
1. Original, not a photocopy
2. No Larger than 2"X2"
3. Taken within one year of application
4. close up, front—not profile
5. Instant Polaroid Photographs **not** acceptable

Applicant's Initials	Date

Height_____

Weight _____

Hair Color _____

Color of Eyes _____

Applicant's Attestation

I, _____, declare under penalty of perjury under the
Print applicant name clearly
laws of the state of Washington that the following is true and correct:

- I am the person described and indentified 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 knowledge.

I understand the Washington 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 _____ at _____
mm/dd/yyyy city/state

By: _____
Signature of applicant

Addendum 6 – Social Security Number Notification

I have not provided a social security number for the following reason:

- ☐ I do not have a social security number, and when I applied for one, it was denied. {attach any correspondence received from the Social Security Administration.}
- ☐ I do not have a social security number, but I have an individual taxpayer identification number, which is _____.
- ☐ I have a social security number, but decline to provide it.
- ☐ I am a foreign national with a student visa only and do not qualify for a social security number because of that visa status.
- ☐ I am a foreign national, not practicing within the United States, and do not qualify for a social security number.
- ☐ I will be in the United States on a visa and cannot apply for a social security number until my visa has been approved and I have entered the United States.
- ☐ Other [Provide a detailed explanation.]

_____

_____

_____

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

_____
Printed Name

_____
Signature

_____
Place Signed

_____
Date Signed

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Washington Medical Commission
P.O. Box 47866
Olympia, WA 98504-7866
medical.commission@wmc.wa.gov
360-236-2750

MD

Associate Professor or Higher Verification

To be completed by the applicant:

Institution name		
Address		
City	State	Zip Code

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of my position as an associate professor or higher in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown above. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Signature of applicant	

To be completed by the facility/agency/program:

_____ has continuously held a position of associate
Applicant Name (Print or type)
professor or higher at the above named institution.

Beginning date (month/year) _____ to Ending date (month/year) _____

Has this applicant had any disciplinary action in the previous five years? ☐ Yes ☐ No

If yes, please explain: _____

_____

(SEAL)

Signature _____

Title _____

Email _____

Address _____

_____

Date _____ Phone _____

Return directly to the address listed above

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at: http://www.fsmb.org/contact-a-state-medical-board/.

Please send this form to: Washington Medical Commission
Attn: MD Credentialing Unit
P.O. Box 47866
Olympia, WA 98504-7866

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

_____
Applicant's signature (must be signed in the presence of a notary)

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

NOTARY:

[Please note: The Notary Public seal should overlap the bottom of the photo to the left. Do not cover the entire face with the seal.]

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.
The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at https://www.fsmb.org/uniform-application/to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at https://www.fsmb.org/contact-a-state-medical-board/ to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to my license number _____ to the board at the address listed below.

Board name	Washington Medical Commission
Mailing address	P.O. Box 47866
City/State/Zip	Olympia, WA 98504-7866

Applicant signature _____ Date_____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____

Name of licensee (last, first, middle, suffix) _____

License type _____ License number _____ Issue date _____ Expiration date _____

1. Is this license current? If not current, please explain: ☐ Yes ☐ No

2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

Title _____ Date _____

(If no seal is available, this form must be notarized.)

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma awarded: _____

Name of school _____

**The social security number is to be used for purposes of identification only and may not be used or any other reason.*

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name	Washington Medical Commission
Mailing address	P.O. Box 47866
City/State/Zip	Olympia, WA 98504-7866

Applicant signature _____ Date _____

Section 2: Medical or Osteopathic School Verification

School name _____

Complete address w/country _____

School name if different when applicant attended _____

Hours of undergraduate education required for admission _____ Total weeks of education applicant attended _____

Attendance (mm/yyyy) from _____ to _____ Graduation date _____ Degree awarded _____

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? **If yes,** indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes ☐ No ☐

☐ Personal or family	From _____ to	☐ Approved	☐ Unapproved
☐ Academic remediation	From _____ to	☐ Approved	☐ Unapproved
☐ Health	From _____ to	☐ Approved	☐ Unapproved
☐ Financial	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a joint degree program	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a non-research special study (e.g., fellowship, intl. experience)	From _____ to _____	☐ Approved	☐ Unapproved
☐ Other _____	From _____ to _____	☐ Approved	☐ Unapproved

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? **If yes,** indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

☐ Academic	From _____ to	☐ Documentation attached
☐ Unprofessional conduct	From _____ to	☐ Documentation attached
☐ Behavioral reasons	From _____ to	☐ Documentation attached
☐ Other _____	From _____ to _____	☐ Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title _____ Date _____

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

Postgraduate Training Verification Form (Form #3)

Institution Name: ____

Institution Address: ____

____

Affiliated School: ____

Applicant: Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

Program Director or designated Official: Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

Section 1:
To be completed by the Applicant.

Name: ______________________________ **Suffix** _____ **Practitioner type: M.D.** ☐ **D.O.** ☐

Date of birth: ____________ **(mm/dd/yyyy)** **SSN*** ______________________________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Name if different when diploma awarded: ______________________________

Board Information:
To be completed by the applicant.

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below:

Board Name: Washington Medical Commission
Mailing address: P.O. Box 47866. Olympia, WA 98504-7866

Applicant Please Sign Here →

Applicant Signature ______________________________ **Date** ____________

Section 2 :
Program Participation :

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected comple ion date in the "To" field.

Use one section per Department/Specialty. If he Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Report Internships, Residencies and Fellowships separately.

Training Level: _____
(e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/Subspecialty: ______________________________

From: __/__/______ **To:** __/__/______

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: _____
(e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/Subspecialty: ______________________________

From: __/__/______ **To:** __/__/______

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: _____
(e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/Subspecialty: ______________________________

From: __/__/______ **To:** __/__/______

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper.
Attach pages as needed.

1. Did this individual ever take a leave of absence or break from his/her training? ---------------- ☐Yes ☐No

2. Was this individual ever placed on probation? -- ☐Yes ☐No

3. Was this individual ever disciplined or placed under investigation? -------------------------------- ☐Yes ☐No

4. Were any negative reports for behavioral reasons ever filed by instructors? -------------------- ☐Yes ☐No

5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ---------------- ☐Yes ☐No

Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form. This section MUST be signed by the program director (M.D. or D.O. only). **(Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)**

Signature: ______________________________

Print name: ______________________________

Title: ______________________________

Email address: ______________________________

Phone Number: ______________________________ **Date:** ____________

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Fifth Pathway Verification Form (Form #4)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

Program Director or Designated Official: Complete Section 2 of this form. Mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma was awarded: _____

Name of medical school _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

Board name	Washington Medical Commission
Mailing address	P.O. Box 47866
City/State/Zip	Olympia, WA 98504-7866

Applicant signature _____ Date _____

Section 2: Fifth Pathway Verification

Institution name _____ Affiliated school _____

Institution name if different when applicant attended _____

Institution address w/country _____

Type of Clinical Rotation	From	To	Weeks Credit

Completed?

☐ Yes. Attendance was from _____ to _____. Completion date was _____.

☐ No. Withdrawal* date was _____. **If the applicant withdrew or was dismissed, please explain below.*

☐ No. Dismissal* date was _____. **If the applicant withdrew or was dismissed, please explain below*

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

Title _____ Date _____

(If no seal is available, this form must be notarized.)

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

WASHINGTON MEDICAL COMMISSION
P.O. Box 47866 | Olympia, WA 98504-7866
360-236-2750 | Medical.Commission@doh.wa.gov

Please Note:

To apply for a physician assistant license, please print pages 24 – 38.

WASHINGTON MEDICAL COMMISSION
P.O. Box 47866 | Olympia, WA 98504-7866
360-236-2750 | Medical.Commission@wmc.wa.gov

Dear Applicant:

The Washington Medical Commission is pleased you have chosen to apply for licensure in Washington. **This application is for Physician Assistant only.**

License Requirements if you hold an active Osteopathic Physician Assistant license:

See **WAC 246-918-082**

- Your Washington State license as an osteopathic physician assistant must be active and unrestricted.
- Submit an allopathic physician assistant application and fee.
- A delegation agreement must be completed and approved by the commission prior to beginning practice.

Note: You may not begin to practice as an allopathic physician assistant until your delegation agreement has been approved and your credentials has been issued.

Initial Applicants

Submit the following documents:

- Official transcripts must be sent directly from your physician assistant program.
- It is the responsibility of the applicant to submit the correct forms to the appropriate entities to obtain verification information is support for the physician assistant license. Documents submitted in support of the application must be submitted directly from the originating source.
- Verification letters sent directly from all states in which you have ever obtained a license to practice as a health care professional. Any Washington license will be verified directly from our data base. Some states require a processing fee. Check with each state to determine this fee.
- Verification of participation in an approved physician assistant program must be received directly from the program director's office. (Form provided)
- Verification of participation in a postgraduate training such as fellowship must be received directly from the program.
- Reporting of any medical malpractice history must be submitted on the Professional Liability section on the online UA. Malpractice information must include detailed information on the nature of the case, date and summary of care given. The applicant must also include copies of all settlement paid by you or on your behalf or judgment. If pending, indicate status.

- The department staff will obtain Federation of State Medical Boards (FSMB) data bank clearance report and the NCCPA Certification. However, if staff is unable to obtain the reports electronically, the applicant will be required to submit requests and pay any applicable fees.

- Physician assistants who have not yet obtained certification by the NCCPA examination may request an Interim Permit. Applicant should submit the request along with an application. Once issued, this permit will be valid for up to one year from the completion of a commission approved physician assistant training program. (Form Provided).

- Physician assistant shall not begin without the Commission's written approval of the delegation agreement. Delegation agreements are to be completed jointly by the physician and physician assistant. Physician assistant may not practice in any area of medicine or surgery that is beyond the sponsoring physician's own usual scope of expertise.

Additional Information:

Prior to applying for license, please read through carefully and consider all of the following:

- Fees submitted with applications for initial credentialing, examinations, renewal, and other fees associated with the licensing and regulation of the profession are non-refundable.

- An application for a license may not be withdrawn after the commission or the reviewing commission member determines that grounds exist for denial of the license or for the issuance of a conditional license.

After the application and fees have been received by the Department of Health, the applicant will be notified if any documents or data are missing. Applicants should allow a minimum of ten to sixteen weeks for processing. Only complete applications will be considered for review. Routine applications require five days for processing. Non-routine applications require more time for processing. All information, documents, data, etc. provided to the department by the applicant will become a part of the file.

For Spouse 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 partners of a service member of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in the 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 state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Uniform Application Physician Assistant Checklist for Licensure

Send this checklist with all other materials being sent to the Board.

Applicant Name _____ Date of Application _____

NOTE: If required items are not submitted, then the application will be considered incomplete and will not be processed until all items requested are received.	**NOT using FCVS to verify credentials**	**Using FCVS to verify credentials**
Completed and submitted online Uniform Application to the Board. Please be sure to list your social security number on your online UA.	☐	☐
Application Fee. (This fee is non-refundable). You can check the online fee page for current fees.		
Notarized Affidavit and Authorization for Release of Information form with 2x2 photo taken within the past 3 months sent to the Board.	☐	☐
Official transcripts must be sent directly from your PA program.	☐	☐
Verification of participation in a postgraduate training such as fellowship must be received directly from the program.		
License verification letters sent directly from all states in which you have ever obtained a license to practice as a health care professional.	☐	☐
Completed addendums 1-5 mailed to the board.	☐	☐
Sent Hospital/Practice Verification form (Addendum page 4-4A) and any applicable fee to verifying organizations.	☐	☐
Supporting documentation of any legal name change sent to the Board.	☐	FCVS handles
Verification of participation in an approved physician assistant program must be received directly from the program director's office.	☐	FCVS handles
Examination Transcripts sent to the Board.	☐	FCVS handles

WASHINGTON MEDICAL COMMISSION
P.O. Box 47866 | Olympia, WA 98504-7866
360-236-2750 | Medical.Commission@wmc.wa.gov

Addendum to Application

Addendum 1 – Physician Assistant Licensure Application Fee Payment Form. Please send your application fee along with this form to the Board immediately upon submission of your application. Please note that your application will not be processed until we receive your application fee.

Addendum 2 – Questions 1-13. 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 questions. If you do not provide this, your application is incomplete, and it will not be considered.

- Question 3 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.
- "Another jurisdiction" means any other country, state, federal territory, or military authority.

Addendum 3 – Interim Permit Request.

Addendum 4 and 4A – Hospital Privileges. Excluding post graduate training, list hospitals where all privileges that have been granted within the past five years. Attach additional pages if you need more space.

Addendum 5 – Applicant's Attestation and Photograph. You must sign and date this form for the Commission to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Attach a current photograph of yourself in the box provided or attach to the application. Indicate the date the photograph was taken. Sign in ink across the bottom of the photo. The photo must be clear, close up, and front view.

Mail all payments and addenda forms to:
The Department of Health
PO Box 1099
Olympia, WA 98507-1099

All verification forms should be returned to the following address by the verifying entity:
Washington Medical Commission
Attn: Credentialing Unit
PO Box 47866
Olympia WA 98504-7866

Addendum 1 – Physician Assistant Licensure Application Fee Payment Form

Please use the licensure fee schedule below to determine the current fees for licensure **(this fee is non-refundable)**. You may pay the required fee by check or money order made payable to the Washington Department of Health. Please send your application fee along with this form to the Board immediately upon submission of your application. Please note that your application will not be processed until we receive your application fee.

Please complete the following information:

Last Name, First Name, and Middle Initial _____ FCVS Profile # (if applicable) _____

Email Address _____ Home Phone _____ Alternate # _____

Mailing Address _____

City _____ State _____ Zip _____

Payment Type:

Check ☐ Check No. _____ Amount: _____

Money Order ☐ Money Order No. _____ Amount: _____

Mail Payment & Payment Form to:
The Department of Health
PO Box 1099
Olympia, WA 98507-1099

Physician Assistant (PA)		**New fees effective 2/1/2020**
Application	$116.00 *	$116.00 *
Two-year renewal	$202.00 *	$379.00 *
Late renewal penalty	$50.00	$124.00
Expired license reissuance	$50.00	$50.00
Duplicate license	$15.00	$15.00

* Includes fee to access the University of Washington (UW) HEAL-WA web site that 2007 legislation requires and the annual $16.00 Washington Physician Health Program surcharge.

The surcharge is assessed at $50.00 on each application and for each year of the renewal period as required in RCW 18.71.310(2) (e.g., a 2-year renewal fee includes $100.00 for the surcharge).

Addendum 2 – Personal Data Questions

Please answer the questions below. If an explanation is asked for, please provide on a separate sheet.

		YES	NO
1.	Do you have a medical condition which in any way currently impairs or limits your ability to practice your profession with reasonable skill and safety? **If yes, please attach any supporting documentation and a detailed explanation.**	☐	☐
	"Medical Condition" includes physiological, medical, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, sleep disorder, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.' You may answer No if the behavior or condition is already known to the Washington Physician Health Program (WPHP). "Known to WPHP" means that you have informed WPHP of your behavior or condition and are complying with all WPHP's requirements for evaluation, treatment, and/or monitoring. **If Yes**, you must submit detailed information to the Commission that will allow the Commission to assess your ability to practice safely, competently, and without impairment to your professional judgement, skill, or knowledge. In addition to this information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Commission. **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 six months. **"Chemical substances"** include alcohol, drugs, or medications, whether taken legally or illegally. Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgements, decisions, orders agreements and surrenders. The department does criminal background checks on all applicants.	☐	☐
3.	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 3, 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.** **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.**	☐	☐

Addendum 2 – Personal Data Questions (Cont.)

		YES	NO
4.	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?	☐	☐
5.	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 judgements, decisions, and agreements?	☐	☐
6.	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?	☐	☐
7.	Have you ever surrendered a credential like those listed in number 6, in connection with or to avoid action by a state, federal or foreign authority?	☐	☐
8.	Have you ever been named in any civil suit or suffered any civil judgement for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
9.	Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☐
10.	Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☐
11.	To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☐
12.	Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☐
13.	Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

Addendum 3 – Interim Permit Request

I hereby request a **one-time only physician assistant interim permit**. I understand that the interim permit will expire one year from the completion of a commission approved physician assistant training program. If, during that year the Commission receives verification from the NCCPA that have passed the examination, this permit will be converted to a full PA-C license.

_____ _____
Signature Date

_____ _____
Print or type full name Date of Birth

_____
Mailing address

_____ _____ _____
City State Zip Code

General Information

A interim permit may be issued upon receipt of the following:

1. Completed application form.
    a. Personal data questions 1-13 must **all** be negative, excluding number 8 regarding malpractice.
2. Interim permit request form.
3. Application and fees paid.
4. Physician Assistant Program Transcript.
5. Physician Assistant Program Director Evaluation Form.
6. Verification from states that the applicant was or is licensed (if applicable).
7. A clear Federation of State Medical Boards (FSMB) data bank clearance report.

Addendum 4 – Hospital Privileges

Hospital Privileges: (*Excluding Post Graduate Training*) List hospitals where all privileges that have been granted within the past five (5) years. Attach additional pages if toy need more space.

- Verifications must be received directly from each hospital. Please send the Hospital Privilege Verification Form (Addendum 4A) to each hospital. This does not include post graduate training hospitals.

	Dates Attended	
Name of Hospital	**Start Date (mm/dd/yyyy)**	**End Date (mm/dd/yyyy)**

_____

Print or type full name

Addendum 4a – Hospital Privilege Verification Form

This section to be completed by the applicant:

Hospital Name: _____

Address: _____

RE: Verification and evaluation of privileges

I am applying for a license to practice as a physician assistant in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

Applicant name _____ Birth date _____
Print or type mm/dd/yyyy

Signature of applicant _____

This section to be completed by the hospital:

1. _____ has/had admitting or specialty privileges at this hospital from _____ to _____.
mm/yyyy mm/yyyy

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration? ☐ Yes ☐ No

   If yes, please explain _____

   _____

   _____

3. Has the applicant ever been asked to resign? ☐ Yes ☐ No If yes, please explain _____

   _____

   _____

Return to: Washington Medical Commission • PO Box 47866 • Olympia, WA 98504-7866 medical.commission@wmc.wa.gov

Seal

Signature _____

Title _____
Please type or print

Hospital _____

Address _____

_____

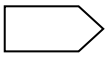
Date _____ Phone _____

Addendum 5 – Applicant's Attestations and Photograph

AIDS Education and Training Attestation

AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by WAC 246-12-290. Course content can be found at WAC 246-12-270.

I certify that I have completed the minimum of four 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.

Photo Here 

Attach Current Photograph here. Indicate Date Taken and Sign in Ink Across the Bottom of the Photo.

Note: Photograph **Must** be:

1. Original, not a photocopy
2. No Larger than 2"X2"
3. Taken within one year of application
4. close up, front—not profile
5. Instant Polaroid Photographs **not** acceptable

Applicant's Initials	Date

Height_____

Weight _____

Hair Color _____

Color of Eyes_____

Signature: _____ **Date of Photo:** _____

Applicant's Attestation

I, _____, declare under penalty of perjury under the
Print applicant name clearly
laws of 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 knowledge.

I understand the Washington 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 _____ at _____
mm/dd/yyyy city/state

By: _____
Signature of applicant

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

PA

Washington Medical Commission
PO Box 47866
Olympia, WA 98504-7866
medical.commission@wmc.wa.gov
360-236-2750

Licensing Board Verification

To be completed by the applicant:

Name of State Medical Board:_____

Address:_____

_____

I am applying for a license to practice medicine as a physician assistant in the state of Washington and before my application can be reviewed, a verification of my license status in your state is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown above. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Signature of applicant	

To be completed by the facility/agency/program:

This is to verify that _____ was issued license
Applicant Name (Print or type)

number _____ on _____
(mm/dd/yyyy)

1. Date license, registration, or certification expires _____
2. Have any complaints been lodged against the license? ☐ Yes ☐ No
3. Is there currently any investigation in process regarding the license? ☐ Yes ☐ No
4. Has any disciplinary activity taken place regarding the license? ☐ Yes ☐ No

If yes, please provide any information or documentation which may be released; i.e., charges and final disposition.

Return to address listed above.

(SEAL)

Signature _____

Title _____

State Board _____

Address _____

_____

Date _____ phone _____

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Washington Medical Commission
PO Box 47866
Olympia, WA 98504-7866
medical.commission@wmc.wa.gov
360-236-2750

PA

Physician Assistant Training Program Director Verification and Evaluation of Training

To be completed by the applicant:

Facility name _____

Address _____

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown above. **All questions must be answered.**

Applicant Name (Print)	Birth date (mm/dd/yyyy)

Signature of applicant

To be completed by the facility/agency/program:

1. _____ is or was engaged in training in our
   Applicant Name (Print)

   program_____

   from beginning date (month and year) _____to ending date (month and year) _____

2. At the time this individual completed the physician assistant program, was the program accredited through the Committee on Allied health Education and Accreditation (CAHEA), the Commission on Accreditation of Allied Health Education Programs (CAAHEP), or the Accreditation Review Committee of Education for the Physician Assistant (ARC-PA? ☐ Yes ☐ No

   If yes, what year the initial accreditation granted? _____

3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☐ No

   If yes, please explain_____

Return to address listed above.

(SEAL)

Signature _____

Title _____

Address _____

City, State, Zip Code _____

Date_____ Phone (enter 10 digit #) _____