



**Washington Board of Osteopathic Medicine & Surgery
Osteopathic Physician and Surgeon License**

**P.O. Box 1099
Olympia, WA 98507-1099
Phone (360) 236-4700
www.doh.wa.gov**

Please Note:

**To apply for a Doctor of Osteopathic license, please print pages 1-22.
To apply for a Physician Assistant license, please print pages 23-41.**



Washington Board of Osteopathic Medicine & Surgery Osteopathic Physician and Surgeon License Uniform Application Instructions

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

Important Social Security Number Information

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360-236-4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

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.

Other Background Information Checked by the Board for All Applicants

- American Osteopathic Association profile
- Federation of State Medical Data Bank Report
- Washington State Criminal Background Report - See "Important Background Check Information" above.
- National Practitioner Data Report

The current address and telephone number of a health care provider governed under chapter 18.130 RCW is not public information.

License Requirements

To qualify for a license to practice osteopathic medicine and surgery in the state of Washington you must have:

1. Graduated from a college or school of osteopathic medicine accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation.
2. Satisfactorily completed a nationally approved one-year internship program or the first year of a residency program approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliated residency accrediting organizations.
3. Completed an examination approved by the Washington Board of Osteopathic Medicine and Surgery. See: Examinations Accepted for Endorsement and State Examination.

General Information

The application process is considered confidential. Information about a pending application will only be provided to the applicant, or a person identified in writing by the applicant.

See [the online fee page](#) for application and other fee amounts.

Applications and supporting documents should be complete at least 60 days before you anticipate beginning work in Washington State. After initial review, more documentation or information may be requested. More time may also be required to complete any investigation requested by the Board. Practice is not permitted prior to issuance of a license.

Verification forms are available in this packet if you are not using FCVS for credentials verification.

All documents must be received from the originating source. Documents verifying your education, training, hospital privileges, or state licenses will not be accepted from you. Copies or faxed documents will not be accepted.

See the checklist at the end of these instructions for the documents required. Addendum forms include Application Questions, Personal Data Questions, Applicant's Attestation, Hospital Investigative Letter (to verify hospital privileges), Training Appointment Verification and Training Investigative Letter.

Temporary Permits

A valid license is required to practice osteopathic medicine and surgery in the state of Washington. A one-time temporary permit may be issued for 180 days if you have a license in another state that has equivalent licensing standards to Washington State. You must have no disciplinary history in any state or any "Yes" answers to the Personal Data Questions. You must apply for a full license. The temporary permit is intended for you to be able to begin work while waiting for issuance of your full license.

Note: Verification of equivalency standards from other states may take longer than it takes to complete the full license application process. Depending on how long it takes to get your documents listed below, you may not benefit by applying for the temporary license. Fees are non-refundable.

Temporary Permit Requirements

- Completed application, endorsement (NBOME only) and temporary permit application fees.
- Documentation from the other state where its licensing standards are equivalent to those of Washington State.
- Verification of all state licenses, whether active or inactive, indicating you are not subject to disciplinary charges or that disciplinary action has not been taken against your license for unprofessional conduct or impairment.
- No "Yes" answers to any Personal Data Question, including #10 regarding malpractice suits.

Examinations Accepted for Endorsement Applications

FLEX/USMLE

- FLEX examination taken prior to June 1985 passed with a FLEX weighted average of at least 75 percent.
- FLEX I and FLEX II examinations with a minimum score of 75 on each component.
- USMLE Steps 1, 2, and 3 with a minimum score as established by the testing agencies.

If your endorsement exam is the FLEX, FLEX I and II, or the USMLE exam, you will also be required to pass the Washington Osteopathic Principles and Practices examination with a 75 percent average.

NBOME/COMLEX

- Parts I, II and III examination given by the National Board of Osteopathic Medical Examiners, **or**
- Level 1, Level 2 CE and/or Level 2 PE, and Level 3 of the COMLEX.

Transcript Request(s)

- For FLEX/USMLE, visit <http://www.fsmb.org/uniform-application/> and click on the Transcripts icon to sign into that area. For assistance, email usmle@fsmb.org or call (817) 868-4041.
- For NBOME/COMLEX, visit <http://www.nbome.org/transcript-request.asp?m-ca> to request that a certified copy of your official transcript be sent directly to this office. For assistance, email transcripts@nbome.org or call 773-714-0622.

State Examination

The USMLE (Step 1, 2, & 3) is the approved state examination after December 1993. Steps 1 and 2 are taken during osteopathic medical school. Other state examinations may be accepted if they include an osteopathic practices and principles section. The Board will determine if they other state's examination is equal to the Washington State examination requirements. Examination scores must be certified by the state where the examination was taken.

USMLE Step 3 Eligibility

To be eligible for USMLE Step 3, you must be a graduate of an accredited osteopathic medical school. Graduation must be confirmed by the Federation of State Medical Board (FSMB) Step 3 deadline date. See <http://www.fsmb.org/licensure/usmle-step-3/> for USMLE requirements, fees, forms, and FAQ.

Application for Limited License While in Postgraduate Training

A limited license is issued to practice osteopathic medicine and surgery while you are training in a postgraduate (internship, residency, or fellowship) program in Washington. The limited license does not authorize you to engage in practice outside the training program. The limited license permits practice only under supervision of a physician licensed in Washington State under chapter 18.57 RCW or chapter 18.71 RCW.

Requirements:

- Completed application form – Check Limited License (Postgraduate Program) and Limited license application fee.
- Official osteopathic school transcripts indicating osteopathic doctorate degree.
- Completion of the Limited License Training Appointment Verification form by the program director from your training program in Washington State.
- Verification of other postgraduate training, hospital privileges, or state licenses as described in the checklist at the end of these instructions, if applicable.

Limited licenses are issued for one year from the beginning date of your postgraduate training and may be renewed annually until completion of the program.

The Federation Credentials Verification Service (FCVS)

The Board accepts the use of the Federation Credentials Verification Service (FCVS) for credentials verification. 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 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 <https://portal.fsmb.org/MyFsmb/> and click on the FCVS icon to sign into that area. 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 Board of Osteopathic Medicine & Surgery Application (Uniform Application) 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://portal.fsmb.org/MyFsmb/> and click on the UA icon to sign into that area. 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. You may need to reselect the US Citizen question on the Identification page as this resets each time you submit the UA. 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. This will be your permanent address with the Department of Health until we have been notified of a change. 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.
- The National Provider Number (NPI) is a standard unique 10-digit numeric identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. Provide this number if you have one.
- 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. If you hold licenses in countries outside the U.S. or Canada, provide that information on a separate sheet of paper to the Board.

- The Chronology of Activities section asks you to list ALL activities (medical and non-medical) in chronological order beginning with medical school graduation. 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 on 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.
- 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 <http://www.fsmb.org/uniform-application/>.

If you are using FCVS for credentials verification,

- Do not complete the medical education or postgraduate verification forms. Do not send any identity documents, transcripts, certificates, or examination scores to the Board. FCVS handles 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. See <http://www.fsmb.org/uniform-application/ua-faq/> for contact information.

For UA assistance, see the UA FAQ at <http://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.

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act (UDA)	RCW 18.130
Administrative Procedure Act (APA).....	RCW 34.05
Administrative Procedures and Requirements	WAC 246-12
Osteopathic Medicine and Surgery RCW.....	RCW 18.57
Osteopathic Medicine and Surgery WAC.....	WAC 246-853

Continuing Education

Osteopathic Continuing Medical Education Rules	WAC 246-853-060-080
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Online

Board of Osteopathic Medicine and Surgery.....	Web page
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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).	<input type="checkbox"/>	<input type="checkbox"/>
Completed State Addendum, all documentation, Notarized UA Affidavit, and check or money order for non-refundable application fee sent to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
AOIA Report Verified by the Board.	<input type="checkbox"/>	<input type="checkbox"/>
FSMB Physician Data Center (Data Bank) Report sent to the Board	<input type="checkbox"/>	<input type="checkbox"/>
Osteopathic School Transcripts sent to the Board by your osteopathic school(s).	<input type="checkbox"/>	Completed via FCVS
Postgraduate Training Verification sent to the Board from all programs you attended.	<input type="checkbox"/>	Completed via FCVS
Examination Transcripts sent to the Board.	<input type="checkbox"/>	Completed via FCVS

Mail your affidavit, addendum, documentation, and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documentation not sent with initial items to:

Osteopathic Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact (360) 236-4700 with any questions.



Washington Board of Osteopathic Medicine & Surgery Osteopathic Physician and Surgeon License Addendum Instructions

Complete the addendum as instructed below. Please type or print your responses. Return the completed addendum along with any and all supporting documentation and additional forms to the Washington Board of Osteopathic Medicine & Surgery.

- **Addendum: 1** – These questions must be completed by the applicant. The AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by [WAC 246-12-260](#). Course content can be found in [WAC 246-12-270](#).

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.

Another jurisdiction means any other country, state, federal territory, or military authority.

You must sign and date the attestation for us to process the application. Read this very carefully.

Training Appointment Verification (For Limited License while in postgraduate training) – If you are applying for a limited license while in postgraduate training, request that the program director of your training program complete this form and return it to the address on the form.

Addendum:2 - Training Investigative Letter – Complete as instructed.

Addendum:3 - Training Appointment Verification – Complete as instructed.

Addendum:4 - Hospital Investigative Letter – Complete as instructed.

Addendum 1



Washington Board of Osteopathic Medicine & Surgery Uniform Application Addendum

Application for: Full License Limited License (Postgraduate Training)

Application for license is made by (check one):

National Board Endorsement Examination FLEX Endorsement/Washington Examination
 USMLE Endorsement/Washington Examination State Examination Endorsement

Will documents be received in another name? Yes No

If yes, list name(s): _____ Medical specialty:

Personal Data Questions: Please answer the following questions. For each "yes" answer, attach a complete signed and dated explanation.

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? Yes No 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:

How your treatment has reduced or eliminated the limitations caused by your medical condition.
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. Yes No

“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? Yes No

4. Are you currently engaged in the illegal use of controlled substances? Yes No

“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 copy 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? Yes No

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 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.

Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction? Yes No

Note: If you answered “yes” to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is complete and will not be considered.

If you answered “yes” to question 5a, do you wish to have the decision on your application delayed until the prosecution and any appeals are complete? Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? Yes No
 - Diverted controlled substances or legend drugs? Yes No
 - Violated any drug law? Yes No
 - Prescribed controlled substances for yourself? Yes No

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. Yes No

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? Yes No
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? Yes No
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? Yes No
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? Yes No
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? Yes No
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? Yes No
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? Yes No
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? Yes No

Hospital Privileges: List hospitals and locations where privileges have been granted within the past five years. If you need more space, attach a piece of paper. Also indicate privileges on the Chronology of Activities page of the online Uniform Application by checking the applicable box.

Name and location of hospital. For locum tenens, enter only those of a 30-day or longer duration.	Dates attended	
	From (mm/yyyy)	To (mm/yyyy)

AIDS Education and Training Attestation: I certify that I have completed a minimum of seven (7) 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 psychological issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. I understand that should I provide any false information my license may be denied, or if issued, suspended or revoked.

Applicant's Initials _____ Date _____

Applicant's Attestation: I, _____, declare under penalty of perjury under the 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 my knowledge.

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 _____ at _____
(mm/dd/yyyy) (city, state)

By _____
(Signature of Applicant)

Addendum 2



Training Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
I have applied for a license to practice osteopathic 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 Osteopathic 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Osteopathic medicine and surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain. _____	
Name:	Title:
Facility	Phone (enter 10 digit #)
Address:	
Authorized Signature:	Date:

Addendum 3



Training Appointment Verification

This is to certify that _____ has been accepted in
Name of osteopathic* physician

a postgraduate training program in _____ at
Type of residency program

_____ for the period beginning
WA State training institution

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

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

Program address _____

Signature _____

* A resident osteopathic physician means an individual who has graduated from an approved school of osteopathic medicine. The resident must be 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 Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations. The term shall include individuals designated as intern, resident, or medical fellow.

Return completed form to the address listed above.

Addendum 4



Osteopathic Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Hospital Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
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I have applied for a license to practice osteopathic 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 Osteopathic Medical Board.

Signature of Applicant:	Date (mm/dd/yyyy):
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1. Does the applicant have, or has he/she ever had 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 osteopathic 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:

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/policy/contacts>.

Please send this form to: Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

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)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

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 _____



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 http://www.fsmb.org/licensure/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 http://www.fsmb.org/policy/contacts 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 Department of Health
Mailing address P.O. Box 1099
City/State/Zip Olympia, WA 98507-1099

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
Title Date
Phone number Fax number
Email

AFFIX INSTITUTIONAL SEAL HERE

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

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

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 for 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	<u>Department of Health</u>
Mailing address	<u>P.O. Box 1099</u>
City/State/Zip	<u>Olympia, WA 98507-1099</u>

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

- | | | | |
|---|---------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Personal or family | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Academic remediation | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Health | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Financial | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Participation in a joint degree program | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Participation in a non-research special study (e.g., fellowship, intl. experience) | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> Unapproved |
| <input type="checkbox"/> Other _____ | From _____ to _____ | <input type="checkbox"/> Approved | <input type="checkbox"/> 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? Yes No **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.

<input type="checkbox"/> Academic	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Unprofessional conduct	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Behavioral reasons	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Other _____	From _____ to _____	<input type="checkbox"/> 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? Yes No **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

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? Yes No **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

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? Yes No **If yes**, explain below and/or attach documentation or information of each circumstance and outcome.

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.

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Signature _____
Print name _____
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.

Institution Name: _____ Institution Address: _____ _____ Affiliated School: _____	<p>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.</p> <p>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.</p>
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Section 1: To be completed by the Applicant. Board Information: To be completed by the applicant. Applicant Please Sign Here →	Name: _____ Suffix _____ Practitioner type: M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Date of birth: _____ (mm/dd/yyyy) SSN* _____ <small>*The social security number is to be used for purposes of identification only and may not be used for any other reason.</small> Name if different when diploma awarded: _____ 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: <u>Department of Health</u> Mailing address: <u>P.O. Box 1099, Olympia, WA 98507-1099</u> Applicant Signature _____ Date _____
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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 completion date in the "To" field. Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations. Report Internships, Residencies and Fellowships separately. Unusual Circumstances: Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper. Attach pages as needed.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; border-right: 1px solid black; padding: 5px;"> Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research </td> <td style="width:67%; padding: 5px;"> Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPCSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these </td> </tr> <tr> <td style="border-right: 1px solid black; padding: 5px;"> Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research </td> <td style="padding: 5px;"> Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPCSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these </td> </tr> <tr> <td style="border-right: 1px solid black; padding: 5px;"> Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research </td> <td style="padding: 5px;"> Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPCSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these </td> </tr> </table> <ol style="list-style-type: none"> 1. Did this individual ever take a leave of absence or break from his/her training? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Was this individual ever placed on probation? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Was this individual ever disciplined or placed under investigation? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Were any negative reports for behavioral reasons ever filed by instructors? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No 	Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPCSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these	Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPCSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these	Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPCSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these
Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPCSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these						
Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPCSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these						
Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPCSC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these						

Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.	<p>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 <u>MUST</u> 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.)</p> Signature: _____ Print name: _____ Title: _____ Email address: _____ Phone Number: _____ Date: _____
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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	Department of Health
Mailing address	P. O. Box 1099
City/State/Zip	Olympia, WA 98507-1099

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 _____
 Title _____ Date _____

AFFIX INSTITUTIONAL SEAL HERE

(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 Board of Osteopathic Medicine & Surgery
Osteopathic Physician and Surgeon License**

**P.O. Box 1099
Olympia, WA 98507-1099
Phone (360) 236-4700
www.doh.wa.gov**

Please Note:

**To apply for a Doctor of Osteopathic license, please print pages 1-22.
To apply for a Physician Assistant license, please print pages 23-41.**



Washington State Department of Health
P.O. Box 1099
Olympia, WA 98507-1099
Phone (360) 236-4700

License Requirements for Osteopathic Physician Assistant

To qualify for your license, you must have graduated from a program approved by the board.

“Board approved program” means a physician assistant program accredited by:

- The Committee on Allied Health Education and Accreditation (CAHEA).
- The Commission on Accreditation of Allied Health Education Programs (CAAHEP).
- The Accreditation Review Committee on Education for the Physician Assistant (ARC-PA).
- Any successor accrediting organization using the same standards.

You must also pass the National Commission on Certification of Physician Assistant (NCCPA) examination within one year of graduation from a physician assistant program.

If you hold an active allopathic physician assistant license: See [WAC 246-854-082](#)

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

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

Initial Applicants

Submit the following documents:

- Transcripts sent directly from your physician assistant program.
- Verification letters sent directly to the board from all hospitals where you were granted privileges within the past five years. If your last employment was in Washington State, verify any hospital privileges you had during your last practice relationship.
- 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 the National Commission on Certification of Physician Assistants, (NCCPA) examination. Show on the application if you are certified. Verification of certification will be obtained by staff.
- A delegation agreement must be completed and approved by the board prior to beginning practice. If you are no longer working with an osteopathic physician supervisor you may either renew your license or let it expire. Keep in mind there will be more fees to reactivate your license in the future. You cannot practice in Washington

without a license and delegation agreement with a supervising physician approved by either the board of Osteopathic Medicine and Surgery (osteopathic physician – DO) or the Medical Quality Assurance Commission (allopathic physician – MD).

Note: All documents must be originals. Copies or faxed documents will not be accepted.

Interim Permit

An interim permit may be issued until the NCCPA certification has been obtained but no longer than one year. Upon receipt of the NCCPA certification, notify the board, and submit the fee to be issued a full license. You are required to have more frequent supervision, limited prescribing authority, and cannot practice in a remote site. An interim permit is issued for one year and cannot be renewed.

Delegation agreement application

Submit the following documents:

- Complete the Osteopathic Physician Assistant application form and submit the documents required for an original license or have a current osteopathic physician assistant license.
- Completed delegation agreement.
- If you transfer from a Washington physician supervisor (either MD or DO), you must have verification letters sent directly from all hospitals where you were granted privileges during the past working relationship.

Prescriptive Authority

A certified osteopathic physician assistant or interim permit holder can issue written or oral prescriptions as provided in [WAC 246-854-030](#) when approved by the board and assigned by the supervising physician.

Supervision and Practice Responsibility

The supervising osteopathic physician is responsible for adequate supervision and review of the osteopathic physician assistant's work. Only those tasks authorized by the board may be performed by the osteopathic physician assistant.

In the temporary absence of the supervising osteopathic physician, the osteopathic physician assistant may carry out those tasks for which they are licensed, if a delegated alternate physician supervisor or physician group provides supervision and review. The osteopathic physician assistant may not function if delegated alternate supervision and review are not available.

An M.D. can be the alternate supervisor for an osteopathic physician assistant licensed under the board.

An osteopathic physician assistant must clearly identify himself or herself as an osteopathic physician assistant and must appropriately display on his or her person identification as on osteopathic physician assistant. See WAC [246-854-015\(6\)](#).

Following termination of supervision, the supervising physician and the osteopathic physician assistant must notify the board in writing within 30 days of the termination and include an explanation.

Additional Information

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required. If your application is incomplete, you will be mailed or emailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Put N/A or place a line through a section instead of leaving it blank.
- You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

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 Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

Hospital Privileges:

List hospitals in the U.S. where hospital privileges have been granted within the past five years. Attach additional pages if you need more space.

- Verification must be received directly from each hospital.
- 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.

AIDS Education and Training Attestation:

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in [WAC 246-12-270](#). If AIDS education was included in your professional education or training, an additional course is not required.

National Provider Identified 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.

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 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.

Address:

List the address we should use to send any information about your license. Be sure to include the city, state, and 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](#).

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

Under the state law, if you are the spouse or state-registered domestic partner 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 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 state’s declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Guide to the Uniform Application and FCVS

The Federation of State Medical Boards

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the 70 medical and osteopathic boards of the United States and its territories, serving as the national resource and voice on behalf of these boards in their protection of the public.

Two services provided by FSMB that are often used by physicians and physician assistants when applying for licensure are the Federation Credentials Verification Service (FCVS) and the Uniform Application for Licensure (UA).

Please be aware that FCVS and the UA are two different services. The FCVS application is only used to establish a profile of credentials verified by primary sources. FCVS is not a licensure application. The UA is used as a licensure application most commonly by physicians and physician assistants applying to multiple state boards. Both services may be used when applying to a board for licensure. Check the board's instructions to determine if FCVS is required or accepted but not required.

Using the UA to Apply for Licensure

The Uniform Application is used to apply for licensure only, not for credentials verification. Once the UA has been completed and the one-time service charge has been paid, it can be updated and sent to other boards as needed. Additional information required by a board, but not covered in the core UA, is gathered by completing a state board specific UA addendum, various board or UA forms, and/or a board's online addendum or separate online application.

Applicants using the UA must account for all time since medical school graduation, or completion of PA program including non-working time as well as postgraduate training and employment. Information on malpractice claims is also required. Having this information on hand before starting the UA is highly recommended.

To begin or update your UA, visit <https://portal.fsmb.org/MyFsmb/> and click on the UA graphic, then sign in. You may also visit <http://www.fsmb.org/> and click on Uniform Application in the Licensure menu to access the portal page.

Completing the UA

When completing your UA online, please complete all pages of the UA as instructed, noting the following:

- Refer to the state board's instructions to determine if entering your social security number is required.
- If not pre-filled, provide your home address and a separate address for business or postgraduate training. Both Board Contact and Public Access selections must be made but you can use the same address for each selection. All home addresses must be domestic, as fingerprint cards and other background information are mailed there.
- Enter each ACGME and/or AOA accredited training on the Accredited Training page. Enter all other training programs in the United States and Canada on the Other Training page. Enter international training programs on the Chronology of Activities page using the PGT/Education type of activity.
- You are not able to add or edit MD, DO or PA license information in the UA because that information is sent directly from the state boards into the FSMB system. If changes are needed, email ua@fsmb.org with the correct information. Depending on volume of license update requests, it may take 1-3 business days for the changes to appear in your UA. Do not enter MD, DO or PA license information under "Other".
- If you hold a medical, osteopathic or PA license or licenses in countries outside of the United States or Canada, provide that information on a separate sheet of paper to the Board.
- Your Chronology of Activities should cover each of your activities (non-working time included) from medical school graduation or completion of PA program to present. Previously listed medical school and postgraduate training programs will pre-fill the Chronology. Do not leave gaps. For each entry, use the first day of the month for start and end dates unless you know the exact date. If you have military or locum tenens assignments, list each location separately.

- Clinical time indicates time spent seeing patients and practicing medicine. Administrative time indicates time spent on paperwork, research, or teaching.
- Leave the malpractice liability claims section blank only if you have had no claims. List all pending claims.
- Upon accepting the Terms and Agreement and submitting the UA, first time UA users will be taken to a payment page for the one-time service charge. This charge sustains the UA program and is separate from FCVS and state board licensing fees.
- For a copy of your receipt, click on the “Home” link to return to the portal page, which will now have a Payment link to all FSMB receipts in the upper right corner.
- To open your UA for editing and resubmitting to a board, or for submitting to a new board, sign in and choose the appropriate board in the State Board section. Reselect the US Citizen query on the Identification page (it resets each time a UA is submitted), make changes as needed, then submit or resubmit your UA.
- Refer to the UA FAQ at <https://www.fsmb.org/licensure/uniform-application/faq> for answers to the most common UA questions. If your issue isn't listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org with your username and a description of your issue. Provide a screenshot for each error you see.

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

- Unless otherwise noted in the board's instructions, submit a notarized 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 to the Board, not to FCVS or FSMB. Follow the instructions on the form.
- Unless otherwise noted in the board's instructions, have each full, temporary, training, or limited healthcare or profession license or certification you have ever held in the United States or Canada verified by the granting board, whether the license is currently active or inactive. To determine the fees and preferred verification method for each board, use the resource at <http://www.fsmb.org/licensure/uniform-application/>. If a board uses VeriDoc or other electronic format for verifications, do not use the UA verification form.
- Complete the FCVS initial or subsequent application if applicable.
- Complete all other board requirements as instructed.

Using FCVS for Credentials Verification

After a physician or a physician assistant completes an initial FCVS application to establish a profile of verified credentials (documents related to identity, medical education, postgraduate training, etc.), FCVS staff contacts the primary source of each credential for verification. Each verified credential is added to a personalized profile created for the physician or physician assistant. Completed verifications are sent to each board designated to receive the profile during the application process.

After a physician or physician assistant completes a subsequent FCVS application, all new credentials are verified through primary sources. An updated profile is then sent to each board designated during the subsequent application process.

Each medical and osteopathic board in the United States and its territories (except for Puerto Rico) accepts or requires FCVS for physician licensure. Many boards accept FCVS for physician assistant licensure. Check the board's instructions to determine if FCVS is required or accepted but not required.

To begin an initial or subsequent application for creating or updating your profile, visit <https://portal.fsmb.org/MyFsmb/> and click on the FCVS graphic, then sign in. You may also visit <http://www.fsmb.org/> and click on FCVS in the Licensure menu to access the portal page. Please note: Designations to Self are for receiving your own copy of the profile. Boards do not accept Self designations.

For assistance, use the messaging tool in FCVS or call 888-275-3287 with your FCVS ID or nine-digit Federation ID (FID) between 8am and 5pm Central Time Monday through Friday.

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.	<input type="checkbox"/>	<input type="checkbox"/>
Application Fee. (This fee is non-refundable). You can check the online fee page for current fee .		
Notarized Affidavit and Authorization for Release of Information form with 2x2 photo taken within the past 3 months sent to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
Official transcripts must be sent directly from your PA program.	<input type="checkbox"/>	<input type="checkbox"/>
Sent AIDS Education and Training Attestation form.	<input type="checkbox"/>	<input type="checkbox"/>
License verification letters sent directly from all states in which you have ever obtained a license to practice as a health care professional.	<input type="checkbox"/>	<input type="checkbox"/>
Completed addendum – personal data questions mailed to the board.	<input type="checkbox"/>	<input type="checkbox"/>
Sent Hospital Privileges documents. List hospitals in the U.S. where hospital privileges have been granted within the past five years.	<input type="checkbox"/>	<input type="checkbox"/>
Supporting documentation of any legal name change sent to the Board.	<input type="checkbox"/>	FCVS handles
Verification of participation in an approved physician assistant program must be received directly from the program director's office.	<input type="checkbox"/>	FCVS handles
Examination Transcripts sent to the Board.	<input type="checkbox"/>	FCVS handles



Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

**Washington Board of Osteopathic Medicine & Surgery
Addenda Instructions for Physician Assistant**

Complete the addendum as instructed below. Please type or print your responses. Return the completed addendum along with any and all supporting documentation and additional forms to the Washington Board of Osteopathic Medicine & Surgery.

Addenda – These questions must be completed by the applicant.

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.

Addendum 1: Applicant’s Personal Data Questions – Complete as instructed.

Addendum 2: Hospital Privileges – Complete as instructed.

Addendum 3: Training Attestation and AIDS Education – Complete as instructed.

Addendum 4: Hospital Investigative Letter – Complete as instructed.

Addendum 5: Osteopathic Physician Assistant Delegation Agreement & Osteopathic Physician Assistant Remote Site Request Form – Complete as instructed.

Addendum 1

Personal Data Questions: Please answer the following questions. For each “yes” answer, attach a complete signed and dated explanation.

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. Yes No

“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. Yes No

“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? Yes No

4. Are you currently engaged in the illegal use of controlled substances? Yes No

“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 copy 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? Yes No

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 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.

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? Yes No
 - b. Diverted controlled substances or legend drugs? Yes No
 - c. Violated any drug law? Yes No
 - d. Prescribed controlled substances for yourself? Yes No
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. Yes No
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? Yes No
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? Yes No
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? Yes No
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? Yes No
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? Yes No
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? Yes No
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? Yes No
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? Yes No

Addendum 2

Hospital Privileges: List hospitals and locations where admitting privileges have been granted within the past five years. If you need more space, attach additional pages. Also indicate privileges on the Chronology of Activities page of the online Uniform Application by checking the applicable box.

Name of hospital and location. For locum tenens, enter only those of a 30-day or longer duration.	Dates attended	
	From (mm/yyyy)	To (mm/yyyy)

Addendum 3

Applicant's Attestation:

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

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 _____ at _____
(mm/dd/yyyy) (City, state)

By _____
(Signature of Applicant)

AIDS Education and Training Attestation: I certify that I have completed a minimum of seven (7) 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 psychological issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information my license may be denied, or if issued, suspended or revoked.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's Initials _____ Date _____

Addendum 4



Osteopathic Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Hospital Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
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I have applied for a license to practice osteopathic 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 Osteopathic Medical Board.

Signature of Applicant:	Date (mm/dd/yyyy):
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1. Does the applicant have, or has he/she had 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 in any status other than good standing? Yes No If so, for what reason?

3. Has the applicant ever been asked to resign or surrender any privileges voluntarily in lieu of or to avoid adverse action?

Yes No If so, for what reason? _____

Name:	Title:
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Facility:	Phone (enter 10 digit #):
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Address:

Authorized Signature:	Date:
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Addendum 5



Osteopathic Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Osteopathic Physician Assistant Delegation Agreement

Name of Physician Assistant		NCCPA Certification	License # If applicable
Business address			
City		State	Zip Code
Phone (enter 10 digit #)	Email Address		County
Primary Supervising Osteopathic Physician (DO Only) (Required)			
Physician name		Specialty	License #
Business address			
City		State	County
Phone (enter 10 digit #)	Email Address		County
Alternate Supervisor (MD or DO)			
Physician name		Specialty	License #
Business address			
City		State	County
Phone (enter 10 digit #)	Email Address		County
Physician Group			
Business Name			
Business address			
City		State	Zip Code
Contact Name		Contact Phone #	
Contact Email Address		Medical Staff Office Phone #	

Standardized Procedures Reference and Guidelines

Responsibility:

The supervising physician and osteopathic Physician Assistant (PA) are both professionally and personally equally responsible for any act performed by the PA as it relates to the practice of medicine.

Supervision of the PA by the physician is the defining hallmark of PA practice and is viewed by physicians and PAs as the major strength of their professional relationship.

Scope of Practice:

PAs may only provide those services that they are competent to perform based on their education, training, and experience and which are consistent with this delegation agreement. The supervising physician and the PA shall determine which procedures may be performed and the degree of supervision under which the PA performs the procedure.

No physician who is designated as a supervising or alternate physician for any PA shall allow that PA to practice in any area of medicine or surgery that is beyond the physician's own usual scope of expertise and practice.

An Interim Permit holder may not practice in remote sites.

Physician Assistant Supervision:

The primary supervisor and the physician assistant must agree upon a plan of supervision based on the physician assistant's training and experience. Specified record reviews and periodic performance evaluations must be part of the plan. Adjustments to the plan must reflect the physician assistant's on-going practice.

Prescriptive Authority:

This delegation agreement allows the PA to prescribe, to order, to administer and to dispense legend drugs and Schedule II-V controlled substances. If a supervising or alternate physician's prescribing privileges are restricted, the PA will be deemed similarly restricted.

Practice Site: (Mark all that apply.)

- A. The PA will be in the same practice site as the supervising physician. When the PA assistant is on duty, the supervising physician or the alternate physicians or physician member of the group practice will be available for on-site supervision or telephone consultation at all times.
- B. The PA will be practicing in a remote site. **If applicable, complete the attached Remote Site Request Form.** Individuals holding an Interim Permit may not practice in a remote site. A remote site is defined as a setting physically separate from the supervising physician's primary place for meeting patients. Or a setting where the physician is present less than twenty-five percent of the practice time of the licensee.

[\(RCW 18.57A.035\)](#)

Practice Sites	% of time in a week PA spends at each setting
Primary Care or Specialty Care Clinic	
Mental Health Facility	
Chemical Dependency Settings	
Home Visit	
Hospital	
Correctional Facility	
Ambulatory Surgical Center	
Adult Family Home Visits	
Nursing Home/Rehabilitation	
Free Standing Urgent Care Clinics	
Emergency Rooms	
Retail Clinics	
Medical Spas	
Hospice Care	
Occupational Medicine	
Other – Please describe	

Practice Arrangements

1. Describe the duties to be performed by PA in each of the practice settings selected above. (Attach additional paper if necessary).

2. Supply a detailed plan for supervision and chart review as required in [WAC 246-854-021\(2\)](#).

3. No physician may supervise more than five PAs without written authorization by the Board. See [RCW 18.57A.040](#) If approval of this delegation agreement results in the supervision of more than five physician assistants, please explain the necessity.

Periods of Absence/Vacation

When the supervising physician is away from the office or practice location for any period of time, including vacation, continuing education or illness:

Check one

____ A designated alternate physician will supervise the PA at all times in accordance with this practice description.

____ The PA will cease to function as such, as no alternate supervisor has been designated.

Other Current Practice Plans:

1. List by name all PAs this physician currently supervises.

2. List by name all the physicians with which this PA has a current delegation agreement.

Termination:

If this delegation agreement is terminated, the board must be notified in writing of that termination by either a letter or email. See [WAC 246-854-021\(8\)](#).

Send notification to:

Osteopathic Credentialing
PO Box 47877
Olympia, Washington 98504

Email: <mailto:HSQACredentialing@doh.wa.gov>

Fax: 360-236-4918

We hereby certify under penalty of perjury under the laws of the State of Washington that the foregoing information in this delegation agreement is correct to the best of our knowledge and belief. We further certify we have reviewed the current rules and regulations of the Board of Osteopathic Medicine and Surgery pertaining to osteopathic physician assistants and this practice description and understand our roles and responsibilities.

Signature of Osteopathic Physician Assistant

Date

Signature of Supervising Osteopathic Physician

Date

Signature of Alternate Physician

Date

(Only required if single alternate supervisor is listed.)

Retain a copy of this delegation agreement as reference and guide for review by a Department of Health representative in the event of a site-review visit.



Osteopathic Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Osteopathic Physician Assistant Remote Site Request Form

A remote site is a practice location where the osteopathic physician is present less than 25% of the practice time of the certified osteopathic physician assistant. See [RCW 18.57A.035](#).

Name of Physician Assistant		License #	
Primary Supervisor Name		License #	
Name of Remote Site			Phone (enter 10 digit #)
Address of remote site			
City	State	Zip Code	

Remote Site Practice Questions:

1. Will the Osteopathic Physician Assistant practice in more than one remote site setting? Yes No
 If yes, list all remote sites. If more than two remote sites, please attach additional pages.

Practice Sites (Please mark all that is applicable to this request.)	What percentage of time per week does the Osteopathic PA spend at each setting?	What percentage of time per week does the supervising physician spend at each setting?	What percentage of time per week are the supervising physician and the osteopathic physician assistant at each setting at the same time?
Supervising physician's primary practice site:			
Remote Site Address:			
Remote Site Address:			

1. Supply a detailed plan for supervision and chart review as provided in [WAC 246-854-015](#).

2. Include an explanation of the community need for utilization of the osteopathic assistant in the remote site.
(Please see [WAC 246-854-025](#) Remote site.)

3. Explain the arrangement made for the osteopathic physician and certified osteopathic physician assistant to communicate in emergent situations.

We hereby certify under penalty of perjury under the laws of the State of Washington that the foregoing information in this delegation agreement is correct to the best of our knowledge and belief. We further certify we have reviewed the current rules and regulations of the Board of Osteopathic Medicine and Surgery pertaining to osteopathic physician assistants and this practice description and understand our roles and responsibilities.

Signature of Osteopathic Physician Assistant

Date

Signature of Supervising Osteopathic Physician

Date

Signature of Alternate Physician
(Only required if single alternate supervisor is listed.)

Date

Retain a copy of this form as reference and guide for review by a Department of Health representative in the event of a site-review visit.