HSQA Office of Customer Service
PO Box 47865
Olympia, WA 98504-7865
360.236.4700

Retired Active Credential Request

Name (please print or type)			
License Number:		Birth Date (mm/dd/yyyy)	
Address			
City	State	Zip Code	County
Country			
Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)	

I, _____,
certify that I am the person described and identified as listed above. I will only practice intermittently (no more than 90 days a year) or in an emergency in the state of Washington. See WAC 246-945-171.

Should I furnish false or misleading information on this declaration, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my credential to practice in the state of Washington.

_____

Applicant's Signature Date

Mail this document with your check or money order to:

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

Documents without a check or money order:

Department of Health
Office of Customer Service
PO Box 47865
Olympia, WA 98504-7865

If you have any questions, please contact the Health Systems Quality Assurance Division, Customer Service Center.

Phone: 360-236-4700

Fax: 360-236-4818

Email: hsqarenewalresearch@doh.wa.gov

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

DOH 690-376 August 2024