Music Therapist Training Program Approval Application Packet

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Important Information:

Mail your application and other documents to:

Music Therapist Training Program

PO Box 47877

Olympia, WA 98504-7877

Or email to:

music.therapist@doh.wa.gov

Contact us:

360-236-4700

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

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Application Checklist and Instructions

To expedite the review process, thoroughly review the following information and use the checklist

to make sure all the required documents are submitted:

- All information must be typed or printed clearly in blue or black ink. You will be notified in writing of any outstanding documentation needed to complete the process.
- Attach program description that outlines competencies and clinical training program hours as identified in WAC 246-837-020
- The application and documents are reviewed by program staff. The reviewer will contact the program representative if there are any minor deficiencies that can be easily corrected.

Use the following checklist to help guide you through the application:

☐ **1. Demographic Information:**

Uniform Business Identifier Number (UBI #): Enter your Washington state UBI number. All Washington State businesses must have UBI numbers. City, county, and state government departments also have UBI numbers.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Entity Name: Enter the owner's name as it appears on the UBI/Master Business License.

Mailing Address: Enter the owner's complete mailing address.

Phone, Fax and Cell Numbers: Enter the owner's phone, cell, and fax numbers.

Email and Web Address: Enter the owner's email and facility Web addresses, if applicable.

Facility/Agency Name: Enter the facility's name as advertised on signs, brochures, or Web site.

Physical Address: Enter the facility's physical street location including city, state, ZIP code, and county.

Phone, Fax and Cell Numbers: Enter the facility's phone, cell, and fax numbers.

Mailing Address: Enter the facility's mailing address, if different from the physical address.

Authorized Representative Name: Enter the facility's authorized representative's name.

Authorized Representative Phone and Email: Enter the authorized representatives' email and phone.

☐ **2. Training Program Criteria:**

Organization: Explain how the organization is specific to music therapy

Accreditation: Provide where the program is accredited must be from an accrediting agency that is recognized by the United States Department of Education or the Council for Higher Education Accreditation

Education Requirement: Enter the education level that is required by the program, must be based on a bachelor's degree or above.

Clinical Training Component: Enter the number of hours of clinical training and how many hours are in internship experience. Must be a minimum of 1200 hours with at least 900 hours in internship experience

☐ **3. Program Representative Attestation:**

The authorized program representative must sign and date this application.

Washington State Department of HEALTH

Date Stamp Here

Music Therapist Training Program Application

Legal Entity Type

- ☐ Association
- ☐ Corporation
- ☐ Federal Government Agency
- ☐ Limited Liability Company
- ☐ Limited Liability Partnership
- ☐ Limited Partnership
- ☐ Municipality (City)
- ☐ Municipality (County)
- ☐ Non-Profit Corporation
- ☐ Partnership
- ☐ Sole Proprietor
- ☐ State Government Agency
- ☐ Tribal Government Agency
- ☐ Trust

1. Demographic Information

UBI Number	Federal Tax ID Number (FEIN)
Legal Owner/Operator Name	
Mailing Address	

City	State	Zip Code	County
Organization or Program Name (Business name as advertised on signs or website)			
Physical Address			
City	State	Zip Code	County
Mailing Address (if different from physical)			
City	State	Zip Code	County

Phone (enter 10 digit number)	Cell (enter 10 digit number)	Fax (enter 10 digit number)
Mailing Address		

City	State	Zip Code	County

2. Training Program Criteria

Organization Description

Accreditation

Education Requirement

Clinical Training Information

Total Hours:

Internship Experience Hours:

3. Signature

I attest that I am the authorized representative of the above-named organization or program, and that I am submitting this application for approval by the Washington State Department of Health in that capacity. I have become familiar with the laws relating to Music Therapists in chapter 18.233 RCW and chapter 246-837 WAC.

I attest that I will submit a new training program application when the program or course changes.

Name of Authorized Representative	Title
Signature of Authorized Representative	Date (mm/dd/yyyy)
Authorized Representative Email	Authorized Representative Phone

RCW/WAC and Online Website Links

RCW Links

Chapter 18.233 RCW, Music Therapist

Chapter 246-837 WAC, Music Therapist

Chapter 34.05 RCW, Administrative Procedure Act

Chapter 246-12 WAC, Administrative Procedures and Requirements for Credentialed Health Care Providers

Online

Web Page