Washington State Department of Health
HSQA Office of Customer Service
PO Box 47865
Olympia, WA 98504-7865
360-236-4700

Retired Active Credential Renewal Declaration of Practice

Name (please print or type)	
License Number	Birth Date (mm/dd/yyyy)

I, _____,
certify that I am the person described and identified as listed above and that in the last renewal cycle, I have practiced only intermittently (no more than 90 days) or in an emergency in the state of Washington.

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 (mm/dd/yyyy)

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