# Dental Anesthesia Assistant Expired Certification Activation Application Packet

## Contents:



## Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

## In order to process your request:

**Mail your application with initial documentation and your check or money order payable to:**

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

**Send other documents not sent with initial application to:**

Dental Quality Assurance Commission
Credentialing
PO Box 47877
Olympia, WA 98504-7877

## 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 civil.rights@doh.wa.gov.

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# Application Instructions Checklist

You will be notified in writing if further documentation is required.

To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay Late Renewal Penalty Fee**.
- ☐ **Pay Current Renewal Fee**.
- ☐ **Pay Expired Certification Reissuance Fee**.
  **All fees are non-refundable.** You can check the online **fee page** for current fees.
- ☐ **1. Demographic Information:**
  **Social Security Number:** You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.

  **National Provider Identifier 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.

  **Legal Name:** List your full name: first, middle, and last.

  **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 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 on this form, your application may be denied.

  **Birth date:** Provide the month, day, and year of your birth.

  **Address:** List the address we should use to send any information about your certification. Be sure to include the city, state, 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**.

  **Phone, Fax, and Cell Numbers:** Enter your phone, fax, and cell numbers, if you have them.

  **Email:** Enter your email address, if you have one.

  **Other Name(s):** Indicate whether you are known or have been known under any other names. 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**.

☐ **2. Other License, Certification, or Registration:** List all credentials you have held since last being credentialed in Washington State. List in date order, most current first, include your last active credentials in Washington State. Attach additional pages if you need more space.

☐ **3. Disciplinary Action Attestation:** Required by **WAC 246-12-040**.

☐ **4. Continuing Education Attestation:** Required by **WAC 246-817-445**.

☐ **5. Supervisor's Attestation:**
The supervisor must review **WAC 246-817-205** and **WAC 246-817-771**.
To act as a supervisor for a certified dental anesthesia assistant, the supervisor must meet the following:

- Have an active dental license.
- Have an active general anesthesia permit.
- The credential or credentials must be in good standing while serving as supervisor.

**Note: If you have multiple supervisors, each supervisor must attest that they meet the above requirements. Attach additional pages as necessary.**

☐ **6. Applicant's Attestation:** Required to be both signed and dated in order to process the application.

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Date Stamp Here

**Revenue: 0251110001**

# Dental Anesthesia Assistant Expired Certification Application

Please print clearly. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

## 1. Demographic Information

| **Social Security Number (SSN)** (If you do not have a SSN, see instructions) | **National Provider Identifier Number (NPI)** (Enter 10 digit number) | ☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X |
|---|---|---|

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

| City | State | Zip Code | County |
|---|---|---|---|

Country

| Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #) |
|---|---|---|

Email address

Name of Oral and Maxillofacial Surgeon or Dental Anesthesiologist

| Washington State: License # | General Anesthesia Permit # |
|---|---|

Business Location

| City | State | Zip Code | County |
|---|---|---|---|

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

## 2. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. Attach additional completed pages if you need more space.

| State | Profession | Credential | | Permanent or temporary | License received by | | Currently in force |
|---|---|---|---|---|---|---|---|
| | | Year issued | Number | | Examination | Other | |
| | | | | ☐ Perm ☐ Temp | | | ☐ Yes ☐ No |
| | | | | ☐ Perm ☐ Temp | | | ☐ Yes ☐ No |
| | | | | ☐ Perm ☐ Temp | | | ☐ Yes ☐ No |
| | | | | ☐ Perm ☐ Temp | | | ☐ Yes ☐ No |
| | | | | ☐ Perm ☐ Temp | | | ☐ Yes ☐ No |
| | | | | ☐ Perm ☐ Temp | | | ☐ Yes ☐ No |

## 3. Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

| Applicant's Initials | Date |
|---|---|
| | |

## 4. Continuing Education/Continuing Competency Attestation

I certify that I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all classes attended/claimed.

| Applicant's Initials | Date |
|---|---|
| | |

## 5. Supervisor's Attestation

As shown in WAC 246-817-205 and WAC 246-817-771. I have met the following requirements:

- Have an active dental license.
- Have an active general anesthesia permit.
- The credential or credentials must be in good standing while serving as supervisor.

I, _____, am a licensed Dentist with

license number _____ and general anesthesia permit number_____

_____ _____

Signature of Dentist Date

**Note: If you have multiple supervisors, each supervisor must attest that they meet the above requirements. Attach additional pages as necessary.**

## 6. Applicant's Attestation

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

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Dental Quality Assurance Commission
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

# Out-of-State Credential Verification

## To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. Instruct them to return the form directly to the address listed above. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

| | | |
|---|---|---|
| Name: Last First Middle | | |
| Mailing Address | | |
| City | State | Zip Code |
| Any other names used: | | |
| Type of healthcare license, certification, or registration: | | |
| License, Certification, or Registration Number | Date Issued | |

Have the licensing agency return this completed form to the address listed above.

If you have any questions, please call 360-236-4700.

## (To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

| | | |
|---|---|---|
| Name of license, certification, or registration holder: | | |
| Authority providing verification: (state, name & title) | | |
| Applicant was credentialed by:<br>☐ Written Examination | Date: | Score: |
| Name of examination: | | |
| ☐ Other Examination | Date: | Score: |
| Name of examination: | | |
| Is credential current: ☐ Yes ☐ No | Expiration Date: | |
| Is this individual considered to be in good standing in your state? ☐ Yes ☐ No<br>If "no," please attach explanation. | | |
| Has this credential ever been denied? ☐ Yes ☐ No<br>Suspended? ☐ Yes ☐ No<br>Revoked? ☐ Yes ☐ No<br>Surrendered? ☐ Yes ☐ No<br>Reinstated? ☐ Yes ☐ No<br>If "yes," please provide a copy of the final order or other documentation of action taken. | | |
| If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No | | |

(SEAL)

Signature: _____

Title: _____

Date: _____

# RCW/WAC and Online Website Links

## RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Dentistry Laws, RCW 18.32

Dentistry Rules, WAC 246-817

Dental Professionals Laws, RCW 18.260

Dental Anesthesia Assistants, RCW 18.350

## Online

Dental Quality Assurance Commission, Web Page