Dentistry Return to Active from Inactive Status (Over Three Years) Application Packet

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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
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

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.

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

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:

☐ **Active Renewal Fee**. This fee is 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 license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with 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 states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

☐ **3. Training and Experience.** Please list in date order all professional work experience. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. Attach additional pages if you need more space.

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

☐ **5. Continuing Education Attestation.** Required by **WAC 246-12-040**.

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

Additional Information:

☐ **Jurisprudence Examination**
Complete the **online examination**. Print and send your certificate of completion with your application. It is a multiple choice exam and designed to familiarize you with the Washington State dentistry laws. Current laws can be found **here**.

☐ **Malpractice Clearance**
Applicants must have malpractice carriers submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted. If coverage is provided via an umbrella policy through a school, or if you are practicing in the military, please indicate in writing.

☐ **Exam Scores**
A notarized copy of the original Examination Board's (WREB, CRDTS, SRTA, NERB) certificate must be sent. This document verifies passage of the examination, date and location taken, and confirms that no outstanding requirements are owed. Examination results will be accepted for up to five years preceding application to Washington State. Applications for the examination should be requested directly from one of the following:

- WREB at 602-944-3315
- CRDTS at 785-273-0380
- SRTA at 757-428-1003
- NERB at 301-563-3300 ext. 227.

Washington State Department of HEALTH

Background Check Stamp Here

Date Stamp Here

Revenue: 0252020000

Dentistry Return to Active Status from Inactive Status (Over Three Years) License Activation Application

Follow all instructions provided. All information should be printed clearly in blue or black ink.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

Mailing address (if different from above)

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 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. Training and Experience

List in date order all of your professional education and experience including college or university pre-dental program, technical or professional school and practice pertaining to the profession for which you are making application. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. You do not have to list continuing education courses. Attach additional pages if you need more space.

Dates		Name and address of institute, place of practice.	Degree/certificate and date received Type of experience or specialty
From (mm/dd/yyyy)	To (mm/dd/yyyy)		

4. 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

5. 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

6. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington 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 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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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act, UDA RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative procedures and requirements, WAC 246-12

Standard of Professional Conduct Rules, WAC 246-16

Dental Professionals Laws, RCW 18.260

Dentistry Rules, WAC 246-817

Dentistry Laws, RCW 18.32

Online

Dental Quality Assurance Commission, Web page

Drug Enforcement Administration (DEA), www.deadiversion.usdoj.gov

Washington State Dental Association, www.wsda.org/

American Dental Association (ADA), www.ada.org/

Required Continuing Education

Continuing education (CE) Training after license has been issued, WAC 246-817-440