



# Osteopathic Physician and Surgeon License 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  
P.O. Box 1099  
Olympia, WA 98507-1099

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

Osteopathic Credentialing  
P.O. 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 [doh.information@doh.wa.gov](mailto:doh.information@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 printed clearly in blue or black ink. It is your responsibility to submit the required forms.

**Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.

**Select if the following applies:**  
Spouse or Registered Domestic Partner of Military Personnel

**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 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. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

**3. Osteopathic Medical Education and Post Graduate Training:**

Verify one year of accredited post-graduate training received in the United States. The Department of Health will verify post-graduate training with the AOIA report. If for any reason this information is not available with AOIA, you will be required to have your program director send verification to this office, including beginning and ending dates.

**4. Experience:**

List in date order, most recent to later, all your professional experience and practice from date of graduation from professional college. Attach additional completed pages if you need more space.

**5. Other License, Certification, or Registration:**

List all states where credentials are or were held. Attach additional pages if you need more space.

**6. Applicant’s Attestation:**

You must sign and date this for us to process the application.

**For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:**

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse’s or registered domestic partner’s military transfer orders to Washington State.

- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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## License Requirements

To qualify for a license to practice osteopathic medicine and surgery in the state of Washington you must have:

- Graduated from a college or school of osteopathic medicine accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation. Provide official osteopathic school transcripts indicating osteopathic doctorate degree.
- Satisfactorily completed a nationally approved one-year internship program or the first year of a residency program approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations.
- Verification of one year of accredited post-graduate training, including internships, residencies, and fellowships. If the Department of Health is unable to verify your post-graduate training with the AOIA report, you will be required to have your program director submit proof of the post-graduate training, to include the beginning and ending dates of the training.
- Completed an examination approved by the Osteopathic Medicine and Surgery Board. See Examinations Accepted for Endorsement and State Examination. Provide verification of a qualifying examination. See “Examinations Accepted for Endorsement and State Examination”.
- Verification letters from all states where you have been issued a license, whether active or inactive. This includes training licenses.

## Temporary Permits

A valid license is required to practice osteopathic medicine and surgery in the state of Washington. A one-time temporary permit may be issued for 180 days if:

- You have a license in another state that has equivalent licensing standards to Washington State.
- You have no disciplinary history in any state or any “Yes” answers to the Personal Data Questions.
- You have applied for a full license.

The temporary permit is intended for you to be able to begin work while waiting for issuance of your full license. You must submit the following to be considered for a temporary permit:

- Completed application, endorsement (NBOME only) and temporary permit application fees. You can check the online [fee page](#) for current fees.
- Documentation from the other state where its licensing standards are equivalent to those of Washington State.

- Verification of all state licenses, whether active or inactive, indicating you are not subject to disciplinary charges or that disciplinary action has not been taken against your license for unprofessional conduct or impairment.

Note: Verification of equivalency standards from the other state may take longer than it takes to complete the full license application process. Depending on how long it takes to get your documents listed below, you may not benefit by applying for the temporary license. Fees are nonrefundable.

## **Examinations Accepted for Endorsement Applications:**

- Parts I, II, and III examination given by the National Board of Osteopathic Medical Examiners or Level 1, Level 2 CE and/or Level 2 PE, and Level 3 of the COMLEX.

Contact: National Board of Osteopathic Medical Examiners, Inc., 8765 W. Higgins Rd, Suite 200, Chicago, IL 60631-4101

Telephone 773-714-0622

Online: <http://www.nbome.org/>

Email: [Candidate\\_Service@nbome.org](mailto:Candidate_Service@nbome.org)

- FLEX examination taken prior to June 1985. Passed with a FLEX weighted average of at least 75 percent.
- FLEX I and FLEX II examinations with a minimum score of 75 on each component.
- USMLE Steps 1, 2, and 3 with a minimum score as established by the testing agencies.

If your endorsement exam is the FLEX, FLEX I and II, or the USMLE exam, you will also be required to pass the Washington Osteopathic Principles and Practices examination with a 75 percent average.

FLEX/USMLE scores: The Federation's Examination and Board Action and History Report (EBAHR) must be sent from:

The Federation of State Medical Boards, P.O. Box 619850, Dallas, TX 75261-9850  
Phone 817-868-4000.

Online: <http://www.fsmb.org.transcripts.html>

- Other state examinations may be accepted if they include an Osteopathic Principles and Practices section. The Board will determine if the other state's examination is equal to the Washington State examination requirements. Examination scores must be certified by the state where the examination was taken.

## **State Examination**

The USMLE (Step 1, 2, and 3) is the approved state examination after December 1993. Steps 1 and 2 are taken during osteopathic medical school. In addition to the USMLE exam, applicants must obtain a 75 percent average on the Washington Osteopathic Principles and Practices examination to complete the examination requirements.



## USMLE, STEP 3 Eligibility

- Graduate of an accredited osteopathic medical school. Graduation must be confirmed by the Federation of State Medical Board (FSMB) Step 3 deadline date.
- The examination application, instructions, and deadline dates may be obtained on the Federation of State Medical Board (FSMB) [website](#).

## Application for Limited License While in Postgraduate Training

A limited license is issued to practice osteopathic medicine and surgery while you are training in a postgraduate (internship, residency, or fellowship) program in Washington. The limited license does not authorize you to engage in practice outside the training program. The limited license permits practice only under supervision of a physician licensed in Washington State under [Chapter 18.57 RCW](#) or [Chapter 18.71 RCW](#).

### Requirements:

- Completed application form - Check Limited License (Postgraduate Program). Limited license application fee. You can check the [fee page](#) for current fees.
- Official osteopathic school transcripts indicating osteopathic doctorate degree.
- Completion of the Limited License Postgraduate Training Verification form by the program director from your training program in Washington State.
- Verification of state licenses as described in the documents required to be submitted section, if applicable.

Limited licenses are issued for one year from the beginning date of your postgraduate training and may be renewed annually until completion of the program.

## Alternative Documents Accepted – Federation Credentials Verification Service (FCVS)

The Federation of State Medical Boards has a central repository for core physician documents. Core documents are defined as the basic documents that do not change, for example, transcripts, postgraduate training, and examination scores. The FCVS is operated on behalf of participating state medical boards but your participation is optional. At your request, those core documents will be provided to the designated state licensing board.

The Board will accept the core documents from FCVS. In addition to the core documents, you may need to submit other documents to complete the application file. You will still be required to provide state verifications and any other information specified in the instructions that apply to your application. The Board may make further inquiries or conduct an investigation related to information provided during the application process.

For information on participating in the FCVS or ordering core documents, contact 1-888-ASK-FCVS (275-3287), Online: <http://www.fsmb.org/fcvs.html>, or email [fcvs@fsmb.org](mailto:fcvs@fsmb.org).

## **Other Background Information Checked by the Board for all Applicants**

- AOA profile
- Federation of State Medical Board Data Bank Report
- National Practitioner Data Bank Report
- Washington State Criminal Background Report

The current address and telephone number of a healthcare provider governed under [RCW 18.130](#) is not public information.

### **Additional Information:**

- The application process is considered confidential. Information about a pending application will only be provided to the applicant, or a person identified in writing by the applicant.
- Applications and supporting documents should be complete at least 60 days before you anticipate beginning work in Washington State. After initial review, more documentation or information may be requested. More time may also be required to complete any investigation requested by the Board. Practice is not permitted prior to issuance of a license.
- Verification forms have been included in the packet for your convenience. You are not required to use these specific forms, but verifications must contain all of the information specified on the forms.
- All documents must be received from the originating source. Documents verifying your education, training, or state licenses will not be accepted from you. Copies or faxed documents will not be accepted.

Date  
Stamp  
Here

Revenue 0252070000

## Osteopathic Medicine and Surgery License Application

Application for (check one):

- Full License  
 Limited License  
 Temporary Permit

Application for license is made by (check one):

- National Board Endorsement  
 FLEX Endorsement/Washington Examination  
 USMLE Endorsement/Washington Examination  
 State Examination Endorsement

Select if the following applies:  Spouse or Registered Domestic Partner of Military Personnel

### 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 address of record

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. Personal Data Questions

Yes No

### Please Note:

**The Board does not inquire about personal medical conditions unless notified that they represent a limitation or impairment to safe medical practice.**

“Medical Condition” includes social, behavioral, physical, physiological, and psychological conditions or disorders. The Board of Osteopathic Medicine and Surgery (BOMS) does inquire about substance use of applicants. If you have a medical condition or substance use disorder that may limit or impair your ability to practice medicine safely, it is your responsibility to contact the Washington Physician Health Program (WPHP) for an assessment: 800-552-7236. If the behavior or condition is “Known to WPHP”, that means you have informed WPHP of your medical condition(s) and you are complying with all WPHP requirements for evaluation, treatment, and/or monitoring - if any. The BOMS considers this a safe haven in the application process.

### Acknowledgement and Agreement

By submitting this application, you acknowledge and agree to the following:

If the Board has information that you may be suffering from a condition for which you are not being appropriately treated that impairs your judgement or would adversely affect your ability to practice medicine in a competent, ethical, and professional manner, the Board may request that you undergo an evaluation with the WPHP or obtain other health examinations at your expense. By submitting this application, you consent to such examination(s). You also agree the full and complete examination report(s) may be provided to the Board, which is the regulatory authority of the license. You waive all claims based on confidentiality or privileged communication. You understand that failure to submit to a required examination(s) or provide the requested report(s) to the Board may be grounds for denying your application.

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

“**Medical Condition**” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

“**Currently**” means within the past six months.

“**Chemical substances**” include alcohol, drugs, or medications, whether taken legally or illegally.

## 2. Personal Data Questions (Cont.)

Yes No

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? .....
4. Are you currently engaged in the illegal use of controlled substances? .....

“Currently” means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs? .....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? . .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? .....
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? .....
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application? .....
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? .....
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? .....

### 3. Osteopathic Medical Education and Post Graduate Training

Provide in date order, most recent to later, your osteopathic educational preparation and post-graduate training. Attach additional completed pages if you need more space.

Schools Attended Osteopathic medical education (list all osteopathic schools attended and location) Post graduate training	Years attended	Dates Granted	
		Start (dd/mm/yyyy)	End (dd/mm/yyyy)

Medical Speciality

### 4. Experience

In date order, most recent to later, list all professional experience since completion of post-graduate training. Exclude activities listed under other sections. Attach additional completed pages if you need more space.

Name of practice or experience and location	From (mm/yyyy)	To (mm/yyyy)	Type of experience or specialty

### 5. Other License, Certification, or Registration

List all credentials to practice osteopathic medicine in any states or US Territories.

State or territory	Certificate		Permanent or Temporary	License Received		Currently in force
	Year	Number		Exam	Other	
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

## 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 \_\_\_\_\_ By: \_\_\_\_\_  
(mm/dd/yyyy) (Original signature of applicant)

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Osteopathic Credentialing  
PO Box 47877  
Olympia, WA 98504-7877  
360-236-4700

## Training Appointment Verification

This is to certify that \_\_\_\_\_ has been accepted in  
Name of osteopathic\* physician

a postgraduate training program in \_\_\_\_\_ at  
Type of residency program

\_\_\_\_\_ for the period beginning  
WA State training institution

\_\_\_\_\_. The individual responsible for this resident's patient care  
Start date

activities will be \_\_\_\_\_.  
Director of program (print name)

Program address \_\_\_\_\_

Signature \_\_\_\_\_

\* A resident osteopathic physician means an individual who has graduated from an approved school of osteopathic medicine. The resident must be serving a period of postgraduate clinical training sponsored by a college or university in this state or by a hospital accredited in this state whose program is approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations. The term shall include individuals designated as intern, resident, or medical fellow.

**Return completed form to the address listed above.**

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Osteopathic Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Training Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
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I have applied for a license to practice osteopathic medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my postgraduate training and return it the address listed above.

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Osteopathic Medical Board.

Signature of Applicant:	Date (mm/dd/yyyy):
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1. Is the applicant currently or has the applicant ever been engaged in postgraduate training in your program?  Yes  No

Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

2. Briefly evaluate the applicant's competence and conduct during the program: \_\_\_\_\_

\_\_\_\_\_

3. Has the program ever had cause to restrict, suspend or terminate, or ask for a voluntary resignation of the applicant's participation in the program?  Yes  No If yes, explain and include performance evaluations. \_\_\_\_\_

\_\_\_\_\_

4. Is there any information in your files that could call into question the applicant's ability to safely practice Osteopathic medicine and surgery?  Yes  No If yes, explain. \_\_\_\_\_

\_\_\_\_\_

Name:	Title:
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Facility:	Phone (enter 10 digit #):
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Address:
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Authorized Signature:	Date:
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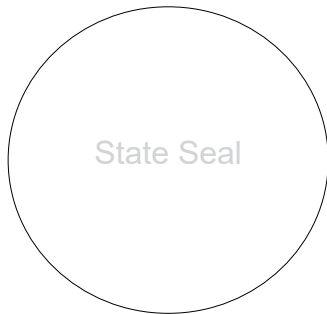


Osteopathic Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## State License Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):
<p>I have applied for a license to practice osteopathic medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my state license and return it the address listed above.</p> <p>Please reply as soon as possible to avoid delays in the licensing process.</p> <p>I hereby authorize you to release the following information to the Washington State Osteopathic Medical Board.</p>	
Signature of Applicant:	Date (mm/dd/yyyy):

<p>To assist the Washington State Board in evaluating the above osteopathic physician's application, we would appreciate receiving the following information.</p>	
License Number:	Date license was issued:
Status of License: <input type="checkbox"/> Active <input type="checkbox"/> Military <input type="checkbox"/> Other <input type="checkbox"/> Inactive <input type="checkbox"/> Expired	
Has the applicant's license ever been suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has any other disciplinary or corrective active been taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the licensee surrendered the license in lieu of disciplinary action? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you have answered yes to any of the questions above, attach supporting documentation pertaining to disciplinary orders or any other actions.	



State Board:	
Address:	
Phone (enter 10 digit #):	
Authorized Signature:	Date:

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## **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](#)

[Osteopathic Medicine and Surgery Laws, RCW 18.57](#)

[Osteopathic Medicine and Surgery Rules, WAC 246-853](#)

### **Continuing Education**

[Osteopathic Continuing Medical Education Rules, WAC 246-853-060](#)

### **Online**

[Board of Osteopathic Medicine and Surgery, Web page](#)