Physical Therapist Expired Credential 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:

Board of Physical Therapy
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 more documentation is needed.

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

- ☐ **Pay** Late Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Pay** Expired Credential Reissuance Fee. **All fees are non-refundable.** You can check the **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 city, state and country where you were born.

  Address: List the address we should use to send any information about your credential. 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 in date order, most recent to later, **all** your credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. Attach additional completed pages if you need more space.

☐ **3: Professional Experience.** List in date order, most recent to later, all your professional work experience since your Washington State credential expired. Attach additional completed pages if you need more space.

☐ **4. Federation of State Boards of Physical Therapy ID Number:**
Please provide your FSBPT ID number

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

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

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

Washington State Department of HEALTH

Date Stamp Here

Revenue 0252080000

Physical Therapist
Expired Credential Activation Application

Please print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could 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	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. Other License, Certification, or Registration

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently In Force	
		Type	Number	Year Issued		No	Yes

3. Professional Experience

Type of experience of practice and location	start (mm/yyyy)	end (mm/yyyy)

4. Federation of State Boards of Physical Therapy ID Number

Please provide your FSBPT ID number _____

5. 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

6. Continuing Education/Continuing Competency Attestation

I certify that I have met all continuing education (32 hours) and competency (200 employment hours) requirements for the past two years.

Applicant's Initials	Date

7. 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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Washington State Department of HEALTH

Board of Physical Therapy Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Board of Physical Therapy Verification of Electroneuromyographic Training by a Qualified Provider

This form may be duplicated. Fill out Section 1 and forward the verification form to the qualified provider for completion.

1. Applicant (print clearly)

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip Code _____

2. Qualified Provider

A qualified provider includes a physical therapist with board certification in clinical electrophysiology from the American Board of Physical Therapy Specialties, a neurologist, a physiatrist, or a person who is board certified in clinical electrophysiology from the American Board of Physical Therapy Specialties.

The above individual seeks verification of training by a qualified provider to place an electroneuromyographic endorsement on his/her physical therapy license. Please complete the following:

Qualified Provider's Name _____ Current Phone _____

Current Street Address _____

City _____ State _____ Zip Code _____

Provider's License Type and License Number _____ Dates Licensed _____

3. Education and Training

A minimum of four hundred hours of electroneuromyographic training is required. Training includes at least two hundred needle EMG studies under direct supervision from a qualified provider.

Hours mentored _____ Describe the activities mentored _____

_____

Qualified Provider/Mentor

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Signature _____ Date _____

Return this form to the above address.

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Washington State Department of HEALTH

Board of Physical Therapy Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Board of Physical Therapy Verification of Mentored Sharp Debridement Education and Training

This form may be duplicated. Fill out Section 1 and forward the verification form to the qualified provider for completion.

1. Applicant (print clearly)

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip Code _____

2. Approved Mentor

The above individual seeks verification of training by a qualified provider to place an electroneuromyographic endorsement on his/her physical therapy license. Please complete the following:

Qualified Provider's Name _____ Current Phone _____

Current Street Address _____

City _____ State _____ Zip Code _____

Mentor's License Type and License Number _____ Dates Licensed _____

3. Mentored Education and Training Specific to Sharp Debridement

A minimum of twenty hours of mentored sharp debridement and training is required. Mentored training includes observation, co-treatment and supervised treatment. Twenty hours mentored training in a clinical setting must include a case mix similar to the physical therapists' expected practice.

Hours mentored _____ Describe the activities mentored _____

_____

_____

Mentor

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Signature _____ Date _____

Return this form to the above address.

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RCW/WAC and Online Website Links

RCW and WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Physical Therapy Laws, RCW 18.74

Physical Therapy Rules, WAC 246-915

Online

Board of Physical Therapy, Web Page

Federation of State Boards of Physical Therapy, (FSBPT), www.fspbt.org

Physical Therapy Association of Washington (PTWA), www.ptwa.org