Podiatric Physician and Surgeon Expired Credential Activation Over 3 Years 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:

Podiatric 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.

(This page intentionally left blank.)

Washington State Department of Health

Application Instructions Checklist

You will be notified in writing if further documentation is required. To ensure that 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 and Substance Abuse Monitoring 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 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** credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. Attach additional pages if you need more space.

☐ **3. Professional Experience.**

In date order, list all your professional work experience since your Washington State credential expired. 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. Hospital Privileges:**

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five years. Attach additional pages if you need more space.

- Verifications must be received directly from each hospital. This does not include post graduate training hospitals.
- Verification for military hospital privileges may be obtained by the current duty station or, if no longer in active service, National Personnel Records Center, Military Personnel Records, 1 Archives Dr, St Louis MO 63138.
- Locum Tenens: Hospital privileges of a 30-day or longer duration.

☐ **7. Applicant's Attestation.**

Required to be both signed and dated in order to process the application.

Additional Documentation Required For Activation:

☐ **Professional Liability Action History.** Malpractice information pertaining to any civil suit or judgment in connection with the practice of a health care profession. Include the nature of the case, date and summary of the care given and settlement amount. The applicant must provide a separate summary of each case and include copies of the settlement or final disposition. If pending, indicate status. If the case is rather old, you should be able to contact the county where it was filed to get the documentation. Please attach on a piece of paper.

☐ **Federation of Podiatric Medical Boards Data Bank Clearance.** The Board requires verification of any disciplinary actions directly from the Federation. Disciplinary reports are $50.00 per report and may be obtained from the Federation, 6551 Malta Drive, Boynton Beach, FL 33437, 561.752.3735. Form provided.

Washington State Department of Health

Date Stamp Here

Revenue 0252010000

Podiatric Physician and Surgeon Credential Activation Application Expired Over 3 Years

Please print clearly in blue or black ink. It is the responsibility of the applicant to submit all 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 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. Disciplinary Action Attestation

I certify that 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 that 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

5. Continuing Education/Continuing Competency Attestation **(If you have one)**

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

6. Hospital Privileges

List hospitals and locations where privileges have been granted within the past five years. Attach additional completed pages if you need more space.

Name of Hospital and Location	Dates	
	Start (mm/yyyy)	End (mm/yyyy)

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)

(This page intentionally left blank.)

Washington State Department of Health
Podiatric Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Hospital Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):

I have applied for a license to practice podiatric 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 hospital privileges 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 Podiatric Medical Board.

Signature of Applicant:	Date (mm/dd/yyyy):

1. Does the applicant have, or has he/she ever had, admitting or specialty privileges at your hospital?

☐ Yes ☐ No Beginning Date: _____ Ending Date: _____

2. Have the applicant's privileges ever been restricted, suspended or revoked by the medical staff or administration, or has he/she ever been asked to resign? ☐ Yes ☐ No If so, for what reason?

_____

_____

3. Has the applicant ever been asked to resign or surrender any privileges voluntarily in lieu of action being taken?

☐ Yes ☐ No If so, for what reason? _____

_____

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

_____

_____

Please attach any copies of information in your records that would provide further information.

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

(This page intentionally left blank.)

Washington State Department of Health
Podiatric 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):
I have applied for a license to practice podiatric 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. 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 Podiatric Medical Board.	
Signature of Applicant:	Date (mm/dd/yyyy):

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

State Seal

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

(This page intentionally left blank.)

Washington State Department of Health
Podiatric Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Podiatric Medical Board
Request for Physician Disciplinary Profile/PMLexis Score Report

This form is to be completed by the podiatric physician and surgeon and mailed directly to the following along with a fee for disciplinary reports plus $45 fee for PMLexis part III score reports (**exam candidates do not need to request scores)**:

Federation of Podiatric Medical Boards
6551 Malta Drive
Boynton Beach, FL 33437
561.752.3735

Beginning March 1, 2004, the Federation of Podiatric Medical Boards will accept orders for PMLexis/Part III score and disciplinary reports via an "order reports" button on its Web site (**www.fpmb.org**). After filling out an on-line form, visitors will have the option to immediately pay for requests with their Master Card or Visa credit card.

Name: _____
First Middle Last

Address: _____
Street City State Zip

Date of Birth: _____ Place of birth: _____
(mm/dd/yyyy) (City/state)

Podiatric Medical School: _____ Date of graduation: _____
(mm/dd/yyyy)

Social Security Number: _____

PMLexis Information: State taken: _____ Date taken: _____
(mm/dd/yyyy)

Applicant Signature _____ Date _____

Federation of Podiatric Medical Boards—Please return this form to the address listed above.

☐ PMLexis Part III Score ☐ Disciplinary Report

Federation Stamp

(This page intentionally left blank.)

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

Podiatric Medicine and Surgery Laws, RCW 18.22

Podiatric Medicine and Surgery Rules, WAC 246-922

Continuing Education

Podiatric Continuing Medical Education Rules, WAC 246-922-300

Online

Podiatric Medical Board Web Page