Prosthetist 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:

Orthotics and Prosthetics 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 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 printed clearly in 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 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 one.

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. Education:**
List in date order, most recent to later, your educational preparation and postgraduate training. Attach additional pages if you need more space.

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

☐ **5. Other License, Certification, or Registration:**
List all states 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.

☐ **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.

License Requirements

Requirements for licensing

To qualify for licensing in Washington, an applicant must:

- Possess a bachelor degree in prosthetics from an approved prosthetics education program.
- Alternatively, a candidate may complete a certificate program in prosthetics from an approved education program.
- Complete a clinical internship or residency of 1900 hours.
- Complete an examination.

Application Requirements

- ☐ A completed application and fee.
- ☐ Official transcripts, certificate, or other documentation forwarded directly from the education program where the applicant has earned a bachelor degree or completed a certificate program from a National Commission on Orthotic and Prosthetic Education (NCOPE) or Commission for Accreditation of Allied Health Education Programs (CAAHEP) accredited program.
- ☐ Provide the **internship form** to show completion of an internship or residency of at least 1900 hours.
- ☐ Applicants who have completed a residency which is approved by the NCOPE or CAAHEP must provide a certificate of completion, a letter from the direct supervisor, or other documentation directly from the residency program.
- ☐ Documentation of successful completion of the American Board for Certification in Orthotics and Prosthetics, Inc. (ABC) written multiple choice and patient simulation examinations for each discipline in which you are applying for a license. The examinations must have been completed after July 1, 1991. Applicants who wish to be referred to ABC by the Department of Health, must submit all application requirements to the Department at least 180 days prior to the examination.
- ☐ Verification of license status from all states and provinces where you have been issued a license to practice orthotics or prosthetics—whether active or inactive, indicating that the applicant is or has not been subject to charges or disciplinary action for unprofessional conduct or impairment.

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Washington State Department of HEALTH

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Prosthetist License Application

Please print clearly. Follow all instructions provided. 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.

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

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 two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

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.

2. Personal Data Questions (cont.)

	Yes	No
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 been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

3. Education and Post Graduate Training

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

Schools attended, full name, city and state	Degree Earned	Dates granted	
		Start Date (mm/yyyy)	End Date (mm/yyyy)

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

5. Other License, Certification, or Registration

List all States or US Territories where credentials are or were held.

State or territory	Certificate		Permanent or Temporary	License received		Currently in force
	Year	Number		Exam	Other	
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

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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Orthotics and Prosthetics Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Internship Training

Applicants must complete an internship of at least 1900 hours in each area for which a license is sought. Individual internships must be completed within a minimum period of one year. The internship must be completed under a supervisor qualified by training and experience in an established facility. The training must include patient management and clinical experience in rehabilitation, acute and chronic care in pediatrics and of adults.

Note: If you have completed a 1900 hour internship or residency program which is approved by the National Commission on Orthotic and Prosthetic Education (NCOPE) or the Commission for Accreditation of Allied Health Education Programs (CAAHEP) you should submit, in lieu of this form, a certificate of completion or other documentation directly from the NCOPE or CAAHEP approved program.

Applicant's Name	Type of Internship ☐ Othotic ☐ Prosthetic

Dates of Internship		Name of Supervisor (Please print)
Start date	End Date	
		Qualifications of supervisor:
Location Address:		
Description of supervised work activities, nature and extent of supervision:		

Dates of Internship		Name of Supervisor (please print)
Start date	End date	
		Qualifications of supervisor:
Location Address:		
Description of supervised work activities, nature and extent of supervision:		

Dates of Internship		Name of Supervisor (please print)
Start date	End date	
		Qualifications of supervisor:
Location Address:		
Description of supervised work activities, nature and extent of supervision:		

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Washington State Department of HEALTH

Orthotics and Prosthetics Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Verification of the American Board for Certification in Orthotics and Prosthetics, Inc. Examination

Applicant Name:	
Please indicate the date the above applicant **successfully completed** the following examinations (not the date certified by ABC):	
Orthotic Written Multiple Choice:	
Orthotic Written Simulation:	
Prosthetic Written Multiple Choice:	
Prosthetic Written Simulation:	
Signature:	Date:

Return this form to the address listed above. If you have any questions regarding the completion of this form, please contact the Office of Customer Service at 360-236-4700.

Note To The Applicant:

Please forward this form to the:

American Board for Certification in Orthotics and Prosthetics, Inc.
330 John Carlyle St., Suite 210
Alexandria, VA 22314

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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

Orthotics and Prosthetics Services Laws, RCW 18.200

Orthotics and Prosthetics Rules, WAC 246-850

Online

Orthotics and Prosthetics Program, Web page