

Dietitian/Nutritionist Expired Certification Activation 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:

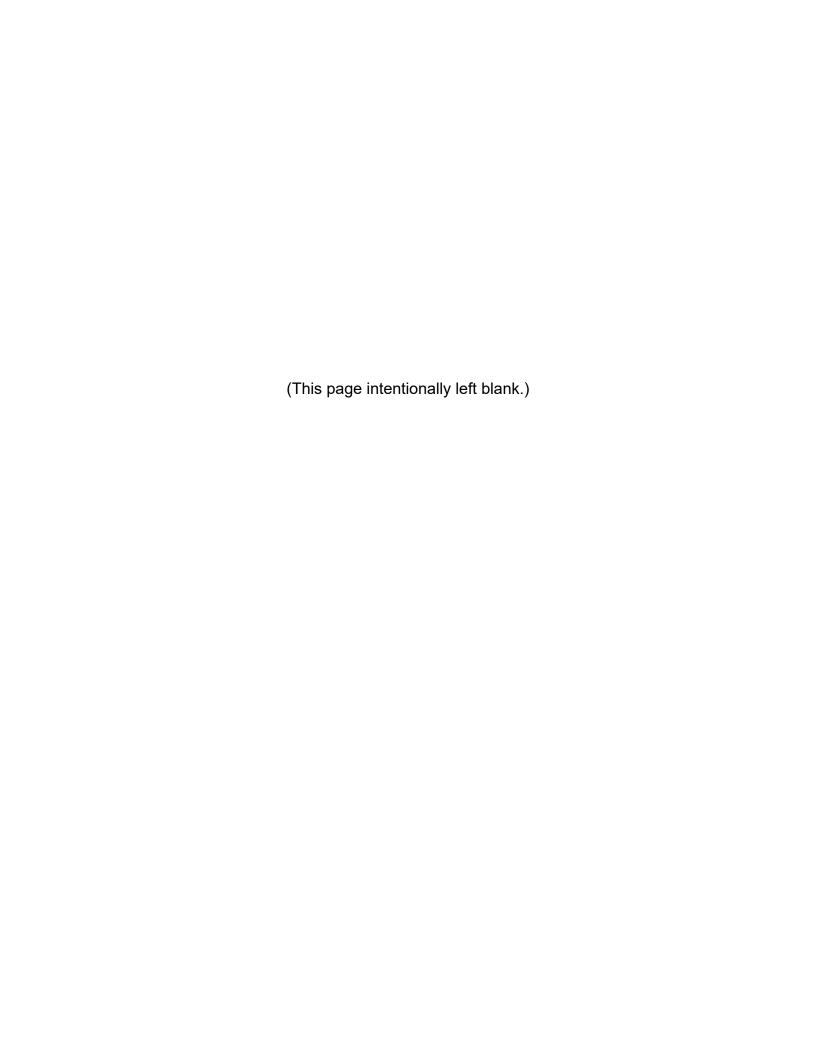
Department of Health PO Box 1099 Olympia, WA 98507-1099 Send other documents not sent with initial application to:

Dietitian and Nutritionist 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.





Application Instructions Checklist

You will be notified in writing if further documentation is required. To ensure you have

mitted the necessary fees and documentation, we encourage you to use the owing checklist:
Pay Late Penalty Fee.
Pay Current Renewal Fee.
Pay Expired Certification Reissuance 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.

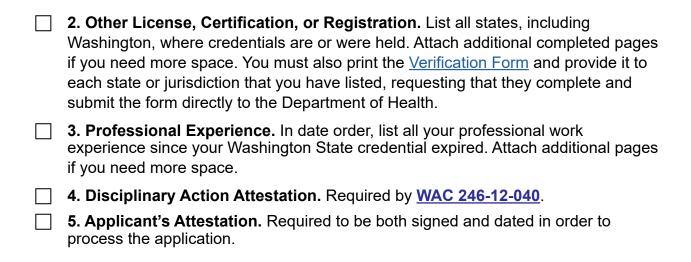
Address: List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See <u>WAC 246-12-310</u>.

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**.

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Rev 0207100000

Dietitian/Nutritionist Expired **Certification Activation Application**

required supporting documents be submitted			. ,		
1. Demographic Information	ı				
Social Security Number (SSN) (If you do not have a SSN, see instructions)		i onal Provide er 10 digit num		ier N	umber (NPI)
Name First		Middle			Last
Birth date (mm/dd/yyyy)					
Address					
City		State	Zip Code	Э	County
Country					
Phone (enter 10 digit #)	Fax ((enter 10 digit i	#)	Cell	(enter 10 digit #)
Email address					
Mailing address of record (if different from al	bove)				
City		State	Zip Cod	de	County
Country					
Note: The mailing and email addresses responsibility to maintain current of			•		•
Have you ever been known under any other	name	e(s)?	No		
If yes, list name(s):					
Will documents be received in another name	e? 🔲 `	Yes 🗌 No			
If yes, list name(s):					

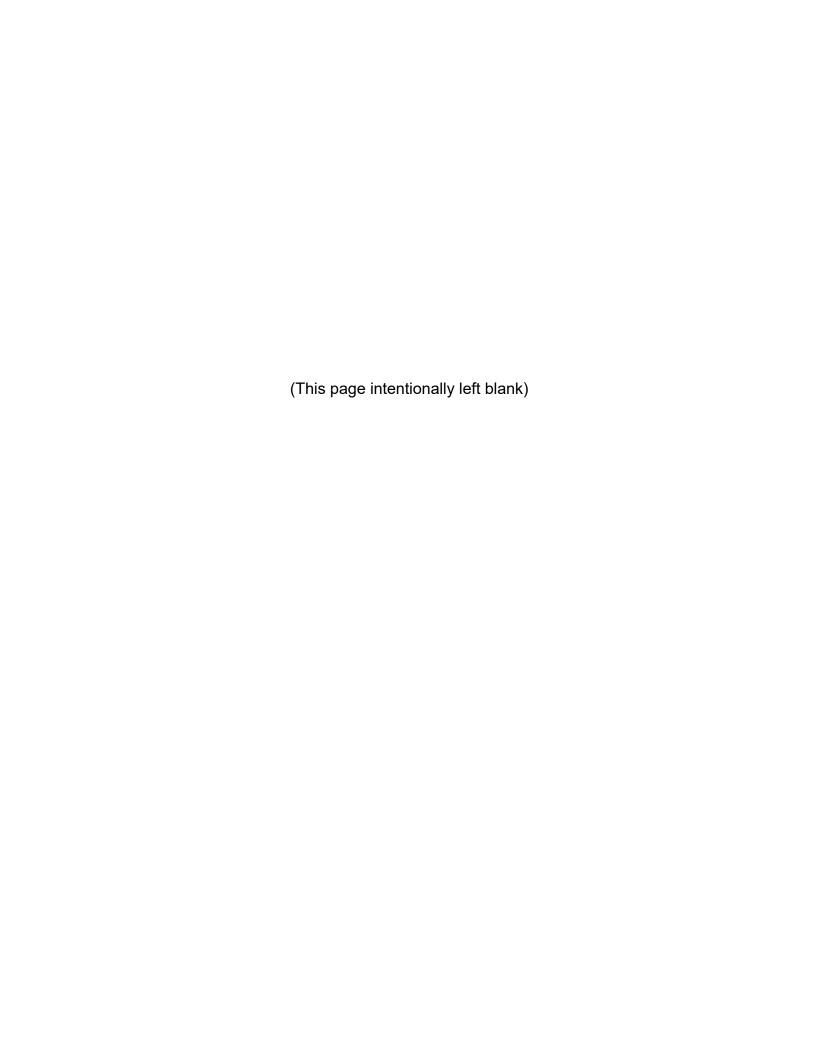
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2. Other Lic	ense, Certific	ation, or I	Registrat	ion			
List all states, includin	g Washington, where cr	edentials are or	were held. Atta	ach additional pag	ges if you	u need mo	ore space.
State/Jurisdiction	License/Certification/	License	/Certification/Re	gistration		Metho Creden	
Ctate/gailealeileii	Registration Type	Year Issued	Number	Expiration Date	Exam	Endorse	Grandfathered
3. Professio	nal Experienc	:e					
	Type of experience		ocation		1)	tart mm/ yyy)	end (mm/yyyy)
4. Disciplina	ary Action Att	estation					
	tion has been taken by practice my professio		ederal jurisdic	ction or hospital	, which	would pre	event or
_	t I have not voluntarily fession in lieu of or to	•	•	orivilege or have	e not be	en restri	cted in the
· ·						APPI	LICANT'S INITIALS

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I,(Print applicant name clearly)	, declare	under penalty of perjury under the laws of
the state of Washington that the following		
I am the person described and ide	entified in this applica	ation.
 I have read <u>RCW 18.130.170</u> and 	RCW 18.130.180 o	f the Uniform Disciplinary Act.
I have answered all questions tru	thfully and completel	y.
The documentation provided in su	upport of my applicat	ion is accurate to the best of my knowledge.
 I have read all laws and rules related 	ated to my profession	ı.
I understand the Department of Health ma The department may independently check		• • • • • • • • • • • • • • • • • • • •
I authorize the release of any files or recordincludes information from all hospitals, edupresent employers and business and profestate, local or foreign government agencies	ucational or other org essional associates.	anizations, my references, and past and
to provide quality health care. If requested department information on my health, included	uding mental health a	and any substance abuse treatment.
Dateu	aı	
(mm/dd/yyyy)		(City, state)
Dated(mm/dd/yyyy)		(City, state)
(mm/dd/yyyy) By:(Signature of applicant)		(City, state)
		(City, state)

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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

Dietitian/Nutritionist Laws, RCW 18.138

Dietitian/Nutritionist Rules, WAC 246-822

Online

Dietitian/Nutritionist Program, Web Page