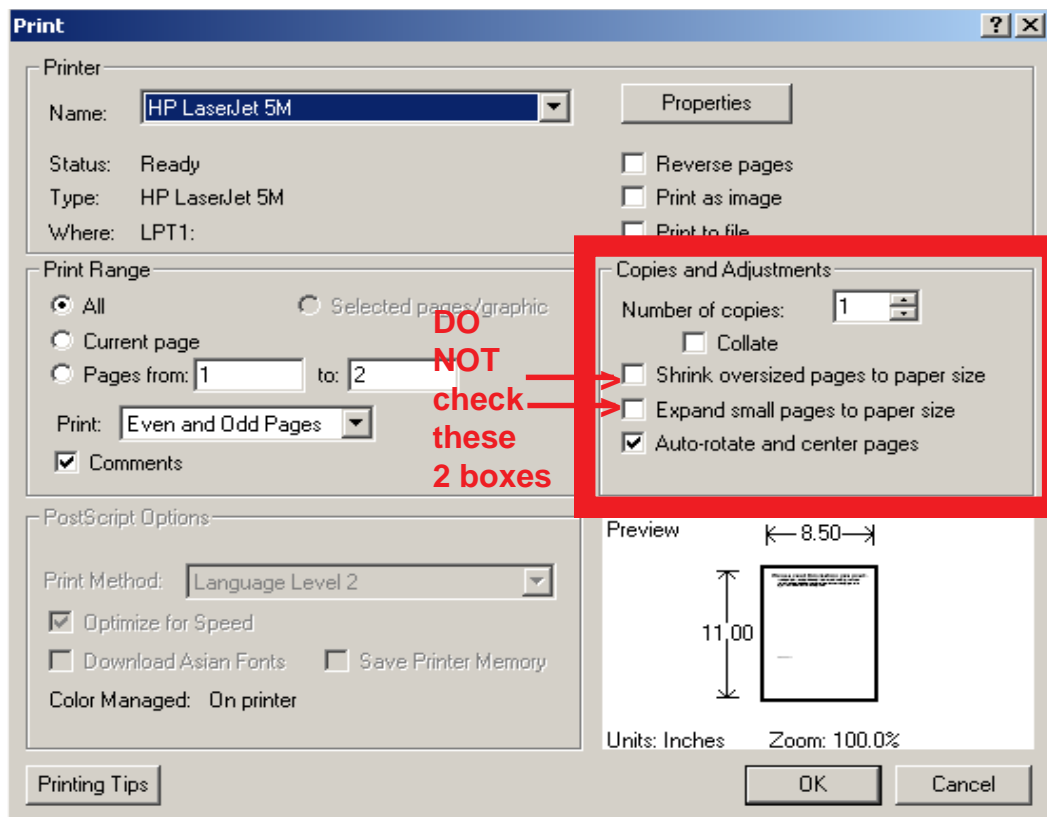


Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box "Auto-rotate and center pages." Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Limited Physicians & Surgeons License Application Packet

- 1. 657-081 .. Contents List/SSN Information/Deposit Slip 1 page
- 2. 657-101 .. Important Information 1 page
- 3. 657-077 .. Application Instructions for Limited Physician & Surgeon Licenses 2 pages
- 3. 657-056 .. Application for Limited License To Practice Medicine Applicable for MDs Only 4 pages
- 4. RCW 18.130.170 2 pages
- 5. RCW 18.130.180 2 pages
- 6. 657-099 .. Applicant's Professional Liability Action History 1 page
- 7. 657-093 .. Request For Medical School Transcripts 1 page
- 8. 657-034 .. Verification/Evaluation of Training 1 page
- 9. 657-008 .. Verification of License/Registration as a Physician 1 page
- 10. 657-017 .. Verification and Evaluation of Privileges 1 page
- 11. 657-057 .. Residency Certification 1 page

B. Important Social Security Number Information:

- * Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your *application fee is not refundable.
- * Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

- 1. Complete the Deposit Slip below.
- 2. Cut Deposit Slip from this form on the dotted line below.
- 3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099.**



Cut along this line and return the form below with your completed application and fees.



Limited Physician

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section

P.O. Box 1099

Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

\$

- Check
- Money Order

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Washington State Department of

Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Important Information

Limited License for Physicians Application/Renewal Fees:

Application Fee \$225.00
Annual Renewal Fee 225.00

WAC 246-919-990 Physician and surgeon fees and renewal cycle. (1) Licenses must be renewed every two years on the practitioner’s birthday as provided in chapter 246-12 WAC, Part 2, except postgraduate training limited licenses and retired active physician licenses. (2) Post-graduate training limited licenses must be renewed every year to correspond to program date.

WAC 246-12-020(3) How to obtain an initial credential. The initial credential will expire on the practitioner’s birthday, except for faculty or postgraduate education credentials authorized by law. Initial credentials issued within ninety days of the practitioner’s birthday do not expire until the practitioner’s next birthday.

WAC 246-12-310 Address changes. It is the responsibility of each practitioner to maintain his or her current address on file with the department. Requests for address changes may be made either by telephone or in writing. The mailing address on file with the department will be used for mailing of all official matters to the practitioner.

Important Telephone Numbers and E-Mail Addresses

Applicants whose last names are between A-L (360) 236-4785
betty.elliott@doh.wa.gov

Applicants whose last names are between M-Z (360) 236-4784
helen.bogar@doh.wa.gov

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Limited Physician & Surgeon Licenses

Application Instructions

Note: A limited license is only for practicing medicine within the confines of the specific training or employment program.

1. Categories of limited licenses with specific requirements:

Internship/Residency Program

- Residency certification (form provided)—The program must certify beginning date of participation. Must be original and direct to this office.

Fellowship or Teaching/Research Program

- Letter of Nomination from the dean of the medical school at the University of Washington or chief executive of hospital or other appropriate health care facility licensed in the state of Washington. The letter must state the program start date.
- License verification from state or country of origin—state license verification must be original and received direct from licensing entity; licenses from country of origin may be a notarized copy of original licensure documents.

Note: A fellowship license has a limit of 2 years total.

Institutions or County-City Health Department

- Original letter verifying employment received directly from official department. The letter must state employment start date.
- License verification from state or country of origin—state license verification must be original and received direct from licensing entity; licenses from country of origin may be a notarized copy of original licensure documents.

2. **Fee**—\$225.00 Checks payable to Department of Health.

3. **All application documentation required:**

- **AIDS**—Applicants must attest to at least four hours of AIDS education either by courses, self-study, or patient care.
- **Chronology** must be complete from receipt of the medical degree to time of application including beginning and ending dates, whether related to the medical practice or not. Applicants must identify any time breaks of more than 30 days.
- **Personal Data Section**—any positive answers to this section must be accompanied by an appropriate explanation and required documentation.
- **Malpractice**—Malpractice information should **INCLUDE** the nature of the case, date and summary of care given. The applicant must complete the Professional Liability Action History form. The applicant must also include copies of the settlement or final disposition. If pending, indicate status.

4. **Transcripts** (form provided)—received direct from Medical School listing dates of attendance, subject completed, degree and date awarded.

- **Foreign Transcripts**—direct from Medical School. All documentation must be translated to English. All translations must be original documents with the appropriate signatures and seals.
- **ECFMG**—(If applicable) A Limited License does not require the ECFMG, however, the applicant must have an ECFMG Indefinite Status sent directly to this office to be considered for full licensure.

5. **Post-Graduate Training Verification—(If applicable)** If you have had prior post-graduate training in another state or province, direct verifications must be completed by the program director and returned directly to this office. (form provided)
6. **State License Verification** (form provided)—**(If applicable)** If you have had a license issued through another state board or province, verification must be sent directly to this office.
7. **Hospital privileges verification—(If applicable)** If you have had hospital privileges, have direct verification sent for all hospitals where applicant has had privileges granted in the past **five** years. (Exclude residency or internship programs.) Forms provided.
8. **Reports—Federation of State Medical Boards Data Bank Clearance and American Medical Association Physician Profile.** These reports will be obtained by Department staff; however, if staff is unable to access these reports electronically, the applicant will be required to submit requests and pay any applicable fees.

Applications and fees are to be sent to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries/documents should be directed to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98507-7866

(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)
(360) 236-4700 (Customer Service Center—Renewals)



Washington State Department of

Health

Health Professions Quality Assurance Division

P.O. Box 1099

Olympia, WA 98507-1099

(360) 236-4785 (A-L)

(360) 236-4784 (M-Z)

FOR OFFICE USE ONLY	
ISSUANCE DATE	
LICENSE #	

LICENSE #

Application For Limited License To Practice Medicine Applicable For MD's Only

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Internship—Residency | <input type="checkbox"/> Teaching—Research | <input type="checkbox"/> Institution |
| <input type="checkbox"/> Fellowship (2 year limit) | <input type="checkbox"/> County—City Health Department | |

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL
------------------	------	-------	----------------

NAME OF INSTITUTION/HEALTH DEPT./MEDICAL SCHOOL/HOSPITAL
--

ADDRESS

CITY	STATE	ZIP	COUNTY
------	-------	-----	--------

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 26.23 RCW)
()	— —

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
<input type="checkbox"/> Female <input type="checkbox"/> Male		

Have you previously applied for a Washington State license or limited license? Yes No

Have you ever been known under any other name(s)? Yes No

If yes, list name(s):

HEIGHT	WEIGHT	Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo. NOTE: Photograph Must Be: 1. Original, not a photocopy 2. No larger than 2" X 2" 3. Taken within one year of application 4. Close up, front view—not profile 5. Instant Polaroid Photographs not acceptable
EYE COLOR	HAIR COLOR	
MEDICAL SCHOOL	YEAR OF GRADUATION	
MEDICAL SPECIALITY		

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 explain.

“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, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered “yes” to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered “yes” to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered “yes” to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in “1b” so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

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

“Currently” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“Chemical substances” includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?

4. Are you currently engaged in the illegal use of controlled substances?

“Currently” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“Illegal use of controlled substances” means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with 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.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

a. the use or distribution of controlled substances or legend drugs?

b. a charge of a sex offense?

c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)

6. Have you ever been found in any civil, administrative or criminal proceedings 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, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?

b. committed any act involving moral turpitude, dishonesty or corruption?

c. violated any state or federal law or rule regulating the practice of a health care professional?

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”, explain 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, or have you ever surrendered such credential to avoid or in connection with action by such authority?

9. 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?

2. Personal Data Questions (Continued)

YES NO

- 10. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?
- 11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?
- 12. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?
- 13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?

3. Education And Experience

Provide a chronological listing of your educational preparation and post-graduate training.
(Attach additional 8 1/2 X 11 sheets if necessary.)

SCHOOLS ATTENDED (LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.)	NUMBER OF YEARS ATTENDED	DATES ATTENDED		DIPLOMA OR DEGREE OBTAINED (QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.)
		FROM (MO/YR)	TO (MO/YR)	
Medical Education (List all Medical Schools Attended)				
Post-Graduate Training (List all Programs Attended)				

4. Professional Experience

In chronological order list all professional experience received since graduation from medical school to the present.
(Exclude activities listed under other sections, identify any periods of time break of 30 days or more.)
(Attach additional 8 1/2 X 11 sheets if necessary.)

	DATES OF EXPERIENCE	
	FROM (MO/YR)	TO (MO/YR)

5. Hospital Privileges

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years.
(Attach additional 8 1/2 X 11 sheets if necessary.)

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	DATES	
	BEGINNING (MO/YR)	ENDING (MO/YR)

6. Licenses In Other States

List all licenses to practice medicine in any state, Canadian province or other country.
(Include whether active or inactive.)

STATE, COUNTY OR PROVINCE	DATE LICENSE ISSUED	LICENSE NUMBER	BASIS OF LICENSURE		STATUS OF LICENSE		ANY LIMITATIONS ON LICENSE
			EXAMINATION (DATE PASSED)	ENDORSEMENT	ACTIVE	INACTIVE	
							<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 <input type="checkbox"/> Yes

7. Fifth Pathway (foreign-trained applicants only) (Attach additional 8 1/2 X 11 sheets if necessary.)

NAME AND LOCATION OF FIFTH PATHWAY PROGRAM	NAME AND LOCATION OF HOSPITAL	DATES ATTENDED	
		BEGINNING (MO/YR)	ENDING (MO/YR)

8. AIDS Affidavit

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my registration may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

9. Applicant's Attestation

I, _____, certify that I am the person described and identified
NAME OF APPLICANT

in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

SIGNATURE OF APPLICANT

DATE

<p>Official Use Only</p> <p>Washington State Records Center</p>

RCW 18.130.170 Capacity of license holder to practice—Hearing—Mental or physical examination—Implied consent.

(1) If the disciplining authority believes a license holder or applicant may be unable to practice with reasonable skill and safety to consumers by reason of any mental or physical condition, a statement of charges in the name of the disciplining authority shall be served on the license holder or applicant and notice shall also be issued providing an opportunity for a hearing. The hearing shall be limited to the sole issue of the capacity of the license holder or applicant to practice with reasonable skill and safety. If the disciplining authority determines that the license holder or applicant is unable to practice with reasonable skill and safety for one of the reasons stated in this subsection, the disciplining authority shall impose such sanctions under RCW 18.130.160 as is deemed necessary to protect the public.

(2)(a) In investigating or adjudicating a complaint or report that a license holder or applicant may be unable to practice with reasonable skill or safety by reason of any mental or physical condition, the disciplining authority may require a license holder or applicant to submit to a mental or physical examination by one or more licensed or certified health professionals designated by the disciplining authority. The license holder or applicant shall be provided written notice of the disciplining authority's intent to order a mental or physical examination, which notice shall include: (i) A statement of the specific conduct, event, or circumstances justifying an examination; (ii) a summary of the evidence supporting the disciplining authority's concern that the license holder or applicant may be unable to practice with reasonable skill and safety by reason of a mental or physical condition, and the grounds for believing such evidence to be credible and reliable; (iii) a statement of the nature, purpose, scope, and content of the intended examination; (iv) a statement that the license holder or applicant has the right to respond in writing within twenty days to challenge the disciplining authority's grounds for ordering an examination or to challenge the manner or form of the examination; and (v) a statement that if the license holder or applicant timely responds to the notice of intent, then the license holder or applicant will not be required to submit to the examination while the response is under consideration.

(b) Upon submission of a timely response to the notice of intent to order a mental or physical examination, the license holder or applicant shall have an opportunity to respond to or refute such an order by submission of evidence or written argument or both. The evidence and written argument supporting and opposing the mental or physical examination shall be reviewed by either a panel of the disciplining authority members who have not been involved with the allegations against the license holder or applicant or a neutral decision maker approved by the disciplining authority. The reviewing panel of the disciplining authority or the approved neutral decision maker may, in its discretion, ask for oral argument from the parties. The reviewing panel of the disciplining authority or the approved neutral decision maker shall prepare a written decision as to whether: There is reasonable cause to believe that the license holder or applicant may be unable to practice with reasonable skill and safety by reason of a mental or physical condition, or the manner or form of the mental or physical examination is appropriate, or both.

(c) Upon receipt by the disciplining authority of the written decision, or upon the failure of the license holder or applicant to timely respond to the notice of intent, the disciplining authority may issue an order requiring the license holder or applicant to undergo a mental or physical examination. All such mental or physical examinations shall be narrowly tailored to address only the alleged mental or physical condition and the ability of the license holder or applicant to

practice with reasonable skill and safety. An order of the disciplining authority requiring the license holder or applicant to undergo a mental or physical examination is not a final order for purposes of appeal. The cost of the examinations ordered by the disciplining authority shall be paid out of the health professions account. In addition to any examinations ordered by the disciplining authority, the licensee may submit physical or mental examination reports from licensed or certified health professionals of the license holder's or applicant's choosing and expense.

(d) If the disciplining authority finds that a license holder or applicant has failed to submit to a properly ordered mental or physical examination, then the disciplining authority may order appropriate action or discipline under RCW 18.130.180(9), unless the failure was due to circumstances beyond the person's control. However, no such action or discipline may be imposed unless the license holder or applicant has had the notice and opportunity to challenge the disciplining authority's grounds for ordering the examination, to challenge the manner and form, to assert any other defenses, and to have such challenges or defenses considered by either a panel of the disciplining authority members who have not been involved with the allegations against the license holder or applicant or a neutral decision maker approved by the disciplining authority, as previously set forth in this section. Further, the action or discipline ordered by the disciplining authority shall not be more severe than a suspension of the license, certification, registration or application until such time as the license holder or applicant complies with the properly ordered mental or physical examination.

(e) Nothing in this section shall restrict the power of a disciplining authority to act in an emergency under RCW 34.05.422(4), 34.05.479, and 18.130.050(7).

(f) A determination by a court of competent jurisdiction that a license holder or applicant is mentally incompetent or mentally ill is presumptive evidence of the license holder's or applicant's inability to practice with reasonable skill and safety. An individual affected under this section shall at reasonable intervals be afforded an opportunity, at his or her expense, to demonstrate that the individual can resume competent practice with reasonable skill and safety to the consumer.

(3) For the purpose of subsection (2) of this section, an applicant or license holder governed by this chapter, by making application, practicing, or filing a license renewal, is deemed to have given consent to submit to a mental, physical, or psychological examination when directed in writing by the disciplining authority and further to have waived all objections to the admissibility or use of the examining health professional's testimony or examination reports by the disciplining authority on the ground that the testimony or reports constitute privileged communications.

[1995 c 336 8; 1987 c 150 6; 1986 c 259 9; 1984 c 279 17.]

NOTES:

Severability—1987 c 150: See RCW 18.122.901.

Severability—1986 c 259: See note following RCW 18.130.010.

RCW 18.130.180 Unprofessional conduct. The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers or documents;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter 19.68 RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

[1995 c 336 9; 1993 c 367 22. Prior: 1991 c 332 34; 1991 c 215 3; 1989 c 270 33; 1986 c 259 10; 1984 c 279 18.]

NOTES:

Application to scope of practice—Captions not law—1991 c 332: See notes following RCW 18.130.010.

Severability—1986 c 259: See note following RCW 18.130.010.

Washington State Medical Quality Assurance Commission Applicant's Professional Liability Action History

Applicant's Name: _____ Today's Date: _____

Please submit a **separate form for each past or current professional liability claim or lawsuit** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

- 1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

Date of occurrence: _____ Details: _____

- 2) Date suit or claim was filed: _____ Name and address of Insurance Carrier that handled the claim: _____

3) Your status in the legal action (primary defendant, co-defendant, other): _____

4) Current status of suit or other action: _____

5) Date of settlement, judgment, or dismissal: _____

- 6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. **(You must enclose a copy of final disposition of case—this includes dismissals.)** \$ _____

I verify the information contained in this form is correct and complete to the best of my knowledge:

SIGNATURE

DATE

(This page intentionally left blank.)

Request For Medical School Transcripts

UNIVERSITY MEDICAL SCHOOL

ADDRESS

I am applying for licensure to practice medicine in the state of Washington. Please send a copy of my medical school transcripts (with the MD degree and date granted posted) directly to the Washington State Medical Quality Assurance Commission at the address below. Thank you for your assistance.

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

Applicant: Please complete the identifying information below to assist the registrar's office in processing your request.

Student Name: _____

Social Security Number: _____

Year of Graduation: _____

Birthdate: _____

(This page intentionally left blank.)

TO: Post Graduate Training Program Director

FACILITY NAME

ADDRESS

RE: Verification/Evaluation of Training

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. **All questions must be answered.**

APPLICANT (PRINT OR TYPE)

BIRTHDATE

SIGNATURE OF APPLICANT

1. _____ is or was engaged in postgraduate training in our program

from _____ to _____
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

in the field of _____.

2. **At the time this individual was in training, was this program accredited through the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons, or the College of Family Physicians of Canada?** Yes No

3. **Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program?** Yes No

If yes, please explain _____

Return to:

Medical Quality Assurance Commission
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(SEAL)

Signature _____

Title _____

Hospital _____

PLEASE TYPE OR PRINT

Address _____

Date _____

Telephone _____

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TO: State Medical Licensing

NAME OF LICENSING AGENCY

ADDRESS

RE: Verification of License/Registration as a Physician

I am applying for a license to practice medicine as a physician and surgeon in the state of Washington and before my application can be reviewed, a verification of my licensure status in your state is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, directly to the address shown below. Please note, all questions must be answered.

APPLICANT (PRINT OR TYPE) BIRTHDATE

SIGNATURE OF APPLICANT

This is verify that _____ was issued license number _____ on _____ .

1. Date license, registration, or certification expires _____

2. Have any complaints been lodged against the license? Yes No

3. Is there currently any investigation in process regarding the license? Yes No

4. Has any disciplinary activity taken place regarding this license? Yes No

If yes, please provide any information or documentation which may be released; i.e., charges and final disposition.

Return to:

Medical Quality Assurance Commission
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Signature _____

Title _____

Hospital _____

PLEASE TYPE OR PRINT

Address _____

Date _____

Telephone _____

(SEAL)

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MD

TO: Hospital Administration

HOSPITAL NAME

ADDRESS

RE: Verification and Evaluation of Privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

APPLICANT (PRINT OR TYPE)

BIRTHDATE

SIGNATURE OF APPLICANT

1. _____ now has/has had admitting or speciality privileges at this hospital

from _____ to _____
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

Yes No

If yes, please explain _____

3. Has the applicant ever been asked to resign? Yes No

If yes, please explain _____

Return to:

Medical Quality Assurance Commission
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Signature _____

Title _____

Hospital _____

PLEASE TYPE OR PRINT

Address _____

Date _____

Telephone _____

(SEAL)

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Washington State Department of
Health

Medical Quality Assurance Commission

PO Box 47866

Olympia WA 98504-7866

(360) 753-2844

(360) 664-8689

LMT

Medical Quality Assurance Commission
Residency Certification

This is to certify that _____ has been

appointed as a resident* in _____ at
SERVICE

the _____ hospital for the period

beginning _____ . The individual responsible for this resident's patient care activities
MONTH DAY YEAR

will be _____ .
(SIGNATURE) DIRECTOR OF PROGRAM

*Residents physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.055 and is serving a period of postgraduate clinical medical training sponsored by a college or university in this state or by a hospital accredited by this state. The term shall include individuals designated as intern or medical fellow.

(Hospital Seal)