



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

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Limited Physicians & Surgeons License Application Packet

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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



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

ADDRESS

CITY	STATE	ZIP	COUNTY
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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
EYE COLOR	HAIR COLOR
MEDICAL SCHOOL	YEAR OF GRADUATION
MEDICAL SPECIALITY	

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

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>

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: _____