Washington State Department of Health

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)

(SEAL)

Signature _____
Title _____
Hospital _____
PLEASE TYPE OR PRINT
Address _____
_____
Date _____
Telephone _____