

# Washington Practitioner Application

**To use the Washington Practitioner Application (WPA), follow these instructions:**

- ❖ **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- ❖ Please sign and date pages 11 and 13.
- ❖ Please document any YES responses on the Attestation Question page.
- ❖ Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ❖ Attach copies of requested documents each time the application is submitted.
- ❖ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ❖ If a section does not apply to you, please check the provided box at the top of the section.
- ❖ Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

**1. INSTRUCTIONS**

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered. *Please do not use abbreviations.* **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- DEA Certificate
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application. Dates need to be listed in mm/yyyy Format)

**\*\* All sections must be completed in their entirety. \*\***

**2. PRACTITIONER INFORMATION – Legal Name Required**

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions, including the date of name change(s) if known (mm/dd/yyyy):			
Home Mailing Address:		City:	
		State:	Zip Code:
Home Telephone Number: ( )	Pager Number: ( )	Cell Phone Number: ( )	E-Mail Address:
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):	Citizenship:	Race/Ethnicity (Optional):
Social Security Number:	<input type="checkbox"/> "Male" <input type="checkbox"/> "Female" <input type="checkbox"/> "X"		Languages Spoken Fluently by Practitioner:
Have you ever voluntarily opted-out of Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/>			
NPI:	Medicare Number: (WA)	Medicaid (DSHS) Number(s):	L & I Number(s):
Specialty primarily practicing:		Sub specialties primarily practicing:	
Other Professional Interests in Practice, Research, etc.:			

**3. PRIMARY PRACTICE INFORMATION Practitioner Start Date (MM/YYYY):** **CHECK ALL THAT APPLY**

<b>Practice Setting</b> <input type="checkbox"/> Clinic/Group <input type="checkbox"/> Solo Practice <input type="checkbox"/> Home Based <input type="checkbox"/> Hospital Based <input type="checkbox"/> Primary Care Site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other	
<b>Practitioner Profile</b> <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Both PCP & OB   OB in your practice <input type="checkbox"/> Yes <input type="checkbox"/> No   Deliveries <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you offer Telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Telehealth:
Are you exclusively Telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Audio <input type="checkbox"/> Visual <input type="checkbox"/> Both
Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):
Primary Office Street Address:	City
	State:
	Zip Code:
	Org. NPI#:
Patient Appointment Telephone Number: (   )	Fax Number: (   )
Mailing Address: (if different from above)	
Billing /Remit Address: (if different from above)	
Office Manager / Administrator Name:	Administration Telephone Number: (   )
	Practice Website:
E-mail Address:	Fax Number: (   )
Credentialing Contact (if different from above):	Telephone Number: (   )
Credentialing Address: (if different from above)	
E-mail Address:	Fax Number: (   )
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Is the office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No Are Gender Affirming treatment services offered? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> Unknown	<b>Office Hours</b>  Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____ Do you provide 24 hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain how your patients obtain advice and care after hours: _____ _____
Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Have you limited your practice in any way (e.g. 18 years or older?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ _____	
Do you currently supervise ARNP's or PA's? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name and specialty below: _____ _____	
Please list languages fluently spoken by office staff: _____ _____	

**A. Hospital Inpatient Coverage Plan (for those without admitting privileges)** **Does Not Apply**  

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

**B. Office Covering Practitioners/Call Group** **Does Not Apply**  

Provider Name, Degree	Specialty	Address	Phone Number

**Attach a list of additional admitting physician/practice/clinic/group or covering practitioners if needed**

<b>Practitioner Start Date at SECONDARY Practice location (MM/YYYY)</b>		<b>CHECK ALL THAT APPLY</b>	
<b>Practice Setting</b>			
<input type="checkbox"/> Clinic/Group <input type="checkbox"/> Solo Practice <input type="checkbox"/> Home Based <input type="checkbox"/> Hospital Based <input type="checkbox"/> Primary Care Site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other			
<b>Practitioner Profile</b>			
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Both PCP & OB   OB in your practice <input type="checkbox"/> Yes <input type="checkbox"/> No   Deliveries <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you offer Telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Telehealth:	
Are you exclusively Telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Audio <input type="checkbox"/> Visual <input type="checkbox"/> Both	
Name of Secondary Practice / Affiliation or Clinic Name:		Department Name (if hospital based):	
Primary Office Street Address:		City:	
		State:	Zip Code:      Org. NPI#
Patient Appointment Telephone Number: (      )		Fax Number: (      )	
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Office Manager / Administrator Name:		Administration Telephone Number: (      )	Practice Website:
E-mail Address:		Fax Number: (      )	
Credentialing Contact (if different from above):		Telephone Number: (      )	
Credentialing Address: (if different from above)			
E-mail Address:		Fax Number: (      )	
Name Affiliated with Tax ID Number:		Federal Tax ID Number:	
Is the office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Hours	
Are Gender Affirming treatment services offered? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> Unknown			
Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			
Have you limited your practice in any way (e.g. 18 years or older?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____			
Do you currently supervise ARNP's or PA's? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name and specialty below: _____			
Please list languages fluently spoken by office staff: _____		Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____ Do you provide 24 hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain how your patients obtain advice and care after hours: _____	
<b>A. Hospital Inpatient Coverage Plan (for those without admitting privileges)</b>			<b>Does Not Apply</b> <input type="checkbox"/>
Name of Admitting Physician/Practice/Clinic/Group:		Hospital Where privileged:	
<b>B. Office Covering Practitioners/Call Group</b>			<b>Does Not Apply</b> <input type="checkbox"/>
<u>Provider Name, Degree</u>	<u>Specialty</u>	<u>Address</u>	<u>Phone Number</u>
<b>Attach a list of additional admitting physician/practice/clinic/group or covering practitioners if needed</b>			

<b>LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET</b>					
<b>4. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS</b> <b>(Attach Additional Sheet if Necessary)</b>					
Washington State Professional License/Registration/Cert Number:		Issue Date:		Expiration Date:	
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).					
Pharmacists Collaborative Drug Therapy Agreement (CDTA) Number(s):					
Drug Enforcement Administration (DEA) Registration Number:				Expiration Date:	
ECFMG Number (applicable to foreign medical graduates):				Date Issued:	
<b>5. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS</b>					
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
<b>6. UNDERGRADUATE EDUCATION (Do not abbreviate)</b> <span style="float: right;"><b>Does Not Apply</b> <input type="checkbox"/></span>					
School/College/University/Vocational Education:		Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)	
Mailing Address:		City:	State:	Zip Code:	
College or University Name:		Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)	
Mailing Address:		City:	State:	Zip Code:	
<b>7. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION</b> <span style="float: right;"><b>Does Not Apply</b> <input type="checkbox"/></span>					
Institution:	Address		City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (     /     ) - (     /     )		Program or Course of Study:			
Faculty Director:	Degree:				
<b>8. MEDICAL/PROFESSIONAL EDUCATION (Do not abbreviate)</b>					
Medical/Professional School:		Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received	
Mailing Address:		City:	State:	Zip Code:	
Medical/Professional School:		Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received	
Mailing Address:		City:	State:	Zip Code:	

<b>9. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)</b>				<b>Does Not Apply</b> <input type="checkbox"/>
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):	
<b>10. RESIDENCIES (Attach Additional Sheet if Necessary)</b>				<b>Does Not Apply</b> <input type="checkbox"/>
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
<b>11. FELLOWSHIPS (Attach Additional Sheet if Necessary)</b>				<b>Does Not Apply</b> <input type="checkbox"/>
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Course of Study:		From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Course of Study:		From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
<b>12. PRECEPTORSHIP (Attach Additional Sheet if Necessary)</b>				<b>Does Not Apply</b> <input type="checkbox"/>
Institution:	Address:	City:	State:	Zip Code:
Telephone Number ( )	Fax Number ( )	Email Address		
Dates Attended (mm/yyyy - mm/yyyy): ( / ) - ( / )	Training:	Department Chairman:		

<b>13. FACULTY/TEACHING APPOINTMENTS (Attach Additional Sheet if Necessary)</b>				<b>Does Not Apply</b> <input type="checkbox"/>	
Institution:		Address:	City:		State: Zip Code:
Telephone Number ( )		Fax Number ( )		Email Address	
Dates Attended (mm/yyyy - mm/yyyy): ( / ) - ( / )		Position:		Faculty Director:	
<b>14. BOARD CERTIFICATION</b>				<b>Does Not Apply</b> <input type="checkbox"/>	
<b>Are you board or otherwise professionally certified?</b>					
<input type="checkbox"/> <b>Yes</b> If "Yes", please complete below:		<input type="checkbox"/> <b>No</b> If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty		Date Certified	Date Recertified	Expiration Date (if any)
Have you applied for certification other than those indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If so, list certification and date:					
Certification number if applicable:					
If you participate in a specialty which does not have board certification, please indicate specialty:					
<b>15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)</b>					
Type:		Number:		Expiration Date:	
Type:		Number:		Expiration Date:	
<b>16. HOSPITAL, MILITARY, &amp; OTHER INSTITUTIONAL AFFILIATIONS</b>				<b>Does Not Apply</b> <input type="checkbox"/>	
Please list in <b>reverse chronological order (with the current affiliation(s) first)</b> all institutions where you (A) Current Hospital affiliation, (B) Previous Hospital Affiliations, (C) Current Military Affiliation, (D) Previous Military Affiliations (E) Applications in process This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.					
<b>A. CURRENT HOSPITAL AFFILIATIONS (Do not abbreviate)</b>					
Name of Primary Admitting Hospital:			Department:		
Mailing Address			City, State, Zip		
Phone number:			Fax Number:		
Status (active, provisional, courtesy, temporary, etc.):		Appointment Date (mm/yyyy):	Medical Staff/Credentialing E-mail Address:		
Can you admit / follow clients of your primary, secondary, other practice locations? <b>Does Not Apply</b> <input type="checkbox"/>					
<input type="checkbox"/> <b>Primary practice admits only</b>		<input type="checkbox"/> <b>Secondary Practice admits only</b>		<input type="checkbox"/> <b>can admit to for all locations</b>	
Name of Secondary Admitting Hospital:			Department:		
Mailing Address			City, State, Zip		
Phone number:			Fax Number:		
Status (active, provisional, courtesy, temporary, etc.):		Appointment Date (mm/yyyy):	Medical Staff/Credentialing E-mail Address:		
Can you admit / follow clients of your primary, secondary, other practice locations? <b>Does Not Apply</b> <input type="checkbox"/>					
<input type="checkbox"/> <b>Primary practice admits only</b>		<input type="checkbox"/> <b>Secondary Practice admits only</b>		<input type="checkbox"/> <b>Can admit to for all locations</b>	

Name of Other Institutions:		Department:	
Mailing Address		City, State, Zip	
Phone number:		Fax Number:	
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):	Medical Staff/Credentialing E-mail Address:	
Can you admit / follow clients of your primary, secondary, other practice locations? <input type="checkbox"/> Primary practice admits only <input type="checkbox"/> Secondary Practice admits only <input type="checkbox"/> Can admit to for all locations		<b>Does Not Apply</b> <input type="checkbox"/>	
<b>B. PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)</b>			
Name of Admitting Hospital:		Department:	
Mailing Address		City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		Medical Staff E-mail Address:	
Name of Admitting Hospital:		Department:	
Mailing Address		City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		Medical Staff E-mail Address:	
Name of Admitting Hospital:		Department:	
Mailing Address		City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		Medical Staff E-mail Address:	
<b>C. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves</b>			
Name of Primary Base:		Division	
Mailing Address		City, State, Zip	
Phone number:		Fax Number:	
Status (active, provisional, courtesy, temporary, etc.):		Appointment Date (mm/yyyy):	
<b>D. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)</b>			
Name of Primary Base:		Division	
Mailing Address		City, State, Zip	
Phone number:		Fax Number:	
Status (active, provisional, courtesy, temporary, etc.):		Appointment Date (mm/yyyy):	

**E. APPLICATIONS IN PROCESS (Do not abbreviate)**

Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted(mm/yyyy)	
Mailing Address:	City:	State:	Zip Code:

**17. WORK HISTORY (Do not abbreviate)**

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. Curriculum vitae is not sufficient.

Name of Practice / Employer:	Contact Name:	Telephone Number: (     )		
Reason for Leaving:	Email Address	Fax Number: (     )		
Mailing Address	City:	State:	Zip:	From (mm/yyyy)    To (mm/yyyy)

Name of Malpractice Carrier During Employment:

Name of Practice / Employer:	Contact Name:	Telephone Number: (     )		
Reason for Leaving:	Email Address	Fax Number: (     )		
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):    To (mm/yyyy):

Name of Malpractice Carrier During Employment:

Name of Practice / Employer:	Contact Name:	Telephone Number: (     )		
Reason for Leaving:	Email Address	Fax Number: (     )		
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):    To (mm/yyyy):

Name of Malpractice Carrier During Employment:

**18. GAPS IN HISTORY. Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:**

	From (mm/yyyy):	To (mm/yyyy):

**19. PEER REFERENCES**

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who, through recent observation, are directly familiar with your work and can attest to your current clinical competence in your specialty area. **Please provide approximate From and To dates you have known the identified peer reference.** If you have been out of residency or fellowship for a period of less than three years, one reference must be from the Program Director. Allied Health Providers must provide at least one reference from their same discipline.

Name of Reference:		Title and Specialty:		E-mail Address:	
Mailing Address:		City:		State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )		From (MM/YY)	To (MM/YY):
Name of Reference:		Title and Specialty:		E-mail Address:	
Mailing Address:		City:		State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )		From (MM/YY)	To (MM/YY):
Name of Reference:		Title and Specialty:		E-mail Address:	
Mailing Address:		City:		State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )		From (MM/YY)	To (MM/YY):

**20. PROFESSIONAL AFFILIATIONS (Do not abbreviate)**

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO

**21. PROFESSIONAL LIABILITY (Do not abbreviate)**

<b>A. Current Insurance Carrier:</b>		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
<b>B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate) (Attach Additional Sheet if Necessary)</b>			
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

<b>Name of Carrier:</b>		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
<b>Name of Carrier:</b>		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
<b>Name of Carrier:</b>		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
<b>Name of Carrier:</b>		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
<b>Name of Carrier:</b>		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
<b>Name of Carrier:</b>		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

**WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - To be completed by the practitioner**

Please answer all of the following questions. If your answer to any of the following questions is "Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

<b>A. PROFESSIONAL SANCTIONS</b>			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
	a.	License to practice any profession in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Other professional registration or certification in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	c.	Specialty or subspecialty board certification	YES <input type="checkbox"/> NO <input type="checkbox"/>
	d.	Membership on any hospital medical staff	YES <input type="checkbox"/> NO <input type="checkbox"/>
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES <input type="checkbox"/> NO <input type="checkbox"/>
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES <input type="checkbox"/> NO <input type="checkbox"/>
	g.	Professional society membership or fellowship	YES <input type="checkbox"/> NO <input type="checkbox"/>
	h.	Participation/membership in an HMO, PPO, IPA, PHO, Health Plan or other entity	YES <input type="checkbox"/> NO <input type="checkbox"/>
	i.	Academic Appointment	YES <input type="checkbox"/> NO <input type="checkbox"/>
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>B. CRIMINAL HISTORY</b>			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES <input type="checkbox"/> NO <input type="checkbox"/>
	a.	Do you have notice of any such anticipated charges?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Are you currently under governmental investigation?	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>C. AFFIRMATION OF ABILITIES</b>			
1.	Do you currently use any substance (legal or illegal) that impairs in any way your ability to practice with skill and safety?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Are you currently suffering from any condition that impairs your judgement or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	If yes to questions 1 or 2, are you currently enrolled in a health professional assistance program authorized by any state licensing entity? <b>If the answer to this question is yes, please complete Section 23 below.</b>		YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>D. LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section 22. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)</b>			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Are there any such claims being asserted against you now?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged)?		YES <input type="checkbox"/> NO <input type="checkbox"/>
5.	Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage?		YES <input type="checkbox"/> NO <input type="checkbox"/>

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Type or Print name here \_\_\_\_\_



**23. Health Professional Assistance Program Disclosure**

Does Not Apply

Please complete below details if you answered yes to Question C.3 above

Name of Monitoring Program

Address of Monitoring Program

Point of Contact Name:

Phone Number

Verification E-mail Address:

**24. ATTESTATION**

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A copy, or electronic PDF with signature authentication, of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name

Here: \_\_\_\_\_

Signature:

\_\_\_\_\_

(Stamped signature is not acceptable)

Date:

\_\_\_\_\_

**Review dates and initials:**

\_\_\_\_\_  
\_\_\_\_\_  
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