Medical Assistant-Registration Expired Activation Application Packet

Contents:

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
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Medical Assistant Credentialing
P.O. 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.

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Application Instructions Checklist

You will be notified in writing if more documentation is needed. We encourage you to use the following checklist to ensure you have submitted the necessary fees and documentation.

- ☐ **Pay** Late Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Pay** Expired Registration 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 about 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 **WAC 246-12-310**.

  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**.
- ☐ **2. Other License, Certification, or Registration:**
  List **all** credentials you have held since last being credentialed in Washington State. List in date order, most current first. Include your last active credential in Washington State. Attach additional pages if you need more space.

☐ **3. Experience:**
List in date order, all your professional work experience since your Washington State credential expired. Attach additional pages if you need more space.

☐ **4. Disciplinary Action Attestation.** Required by **WAC 246-12-040**.

☐ **5. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

Attestation Endorsement

You must have a current attestation of your employment **form** to perform specific tasks signed by a health care practitioner or representative of a clinic or group practice filed with the department. You may only perform the medical tasks listed in your current attestation endorsement.

Washington State Department of HEALTH

Medical Assistant Credentialing
P.O. Box 1099
Olympia, WA 98507-1099

Date Stamp Here

Revenue: 0252625081

Medical Assistant-Registration Expired Activation Application

Please print clearly. It is the responsibility of the applicant to submit all supporting documentation. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

Facility Information

Facility Name

Facility Mailing Address

City	State	Zip Code

County

2. Other License, Certification, or Registration

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently In Force	
		Type	Number	Year Issued		No	Yes

3. Experience

Type of experience of practice and location	start (mm/yyyy)	end (mm/yyyy)

4. Criminal and Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

The department does criminal background checks on all applicants.

Applicant's Initials	Date

5. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ By: _____
(mm/dd/yyyy) (Original signature of applicant)

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Medical Assistant Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Medical Assistant-Registered Healthcare Practitioner Endorsement

Applicant:
Use this form for medical assistant-registered endorsement. All information should be printed clearly in blue or black ink. This form may be duplicated.

An endorsement must be signed by a healthcare practitioner as defined in RCW 18.360.010.

- You may only perform the medical tasks listed in your current attestation for endorsement, as listed in RCW 18.360.050(4). Do not add additional tasks to this form.
- A new endorsement form must be submitted within 30 days if your tasks change.
- Your endorsement is valid as long as you are continuously employed as a medical assistant-registered by the same healthcare practitioner, clinic or group and you renew your registration.
- Your endorsement is not transferable to another healthcare practitioner, clinic or group practice.

Fill out section one and forward to the healthcare practitioner for completion of sections two through four.

1. Print clearly:

Name Last	First	Middle

Birth Date (mm/dd/yyyy)	Social Security Number

Address

City	State	Zip Code

2. Healthcare Practitioner:

Applicant Date of Hire: _____
(mm/dd/yyyy)

The above individual seeks verification of supervised medical assisting and endorsement as a medical assistant-registered. Please complete the following:

Healthcare Practitioner (check all that apply)

☐ MD ☐ DO ☐ MD-PA ☐ DO-PA ☐ ARNP ☐ RN ☐ DPM ☐ ND ☐ OD

Healthcare Practitioner Name	Phone (enter 10 digit #)

Healthcare Practitioner License Number	License Expiration Date

Practice Setting (Check One):
☐ Group Practice ☐ Clinic ☐ Physician's Office ☐ Hospital ☐ Other Healthcare Facility

3. Facility Information:

Facility Name		
Facility Mailing Address		
City	State	Zip Code

4. Healthcare Practitioner Attestation:

I_____ attest that
Healthcare Practitioner (type or print)

_____ will assist
Medical Assistant-Registered Name (type or print)

with patient care and perform administrative and clinical procedures.

I attest appropriate supervision will be provided to the medical assistant-registered in carrying out the procedures delegated.

I attest the medical assistant-registered has demonstrated competency to perform the following tasks:

	Yes	No
a. Fundamental procedures:		
i. Wrapping items for autoclaving	☐	☐
ii. Procedures for sterilizing equipment and instruments	☐	☐
iii. Disposing of biohazardous materials	☐	☐
iv. Practicing standard precautions	☐	☐
b. Clinical procedures:		
i. Preparing for sterile procedures	☐	☐
ii. Taking vital signs	☐	☐
iii. Preparing patients for examination	☐	☐
iv. Observing and reporting patients' signs or symptoms.	☐	☐
c. Specimen collection:		
i. Obtaining specimens for microbiological testing	☐	☐
ii. Instructing patients in proper technique to collect urine and fecal specimens	☐	☐
iii. Finger and/or heel stick to collect a blood specimen	☐	☐

d. Patient care:

i. Telephone and in-person screening limited to intake and gathering of information without requiring the exercise of judgment based on clinical knowledge ☐ ☐

ii. Obtaining vital signs ☐ ☐

iii. Obtaining and recording patient history ☐ ☐

iv. Preparing and maintaining examination and treatment areas ☐ ☐

v. Preparing patients for and assisting with routine and specialty examinations, procedures, treatments, and minor office surgeries utilizing no more than local anesthetic. ☐ ☐

vi. Maintaining medical and immunization records ☐ ☐

vii. Screening and following up on test results as directed by a healthcare practitioner ☐ ☐

e. i. Tests waived under the federal clinical laboratory improvement (CLIA) amendments program ☐ ☐

ii. Moderate complexity tests if the medical assistant-registered meets standards for personnel qualifications and responsibilities in compliance with federal regulation for nonwaived testing. ☐ ☐

f. Administering eye drops, topical ointments, and vaccines, including combination or multidose vaccines. ☐ ☐

g. Urethral catheterization when appropriately trained ☐ ☐

I attest that the above information is accurate and complete to the best of my knowledge.
I understand that the Department of Health may request additional information, if it is needed.

_____ _____

Original Signature—Healthcare practitioner | Date (mm/dd/yyyy)

_____ _____

Original Signature—Medical Assistant-Registered | Date (mm/dd/yyyy)

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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

Medical Assistant Law, RCW 18.360

Medical Assistant Rules, WAC 246-827

Online

Medical Assistant, Web Page

Get important information about your credential type by **subscribing to email alerts**.