Medical Cannabis Consultant Expired Certificate 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 Cannabis Consultant
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 further documentation is required.

To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay** Late Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Pay** Expired License Reissuance Fee.
  All fees are non-refundable. You can check the **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.

  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 on your license. 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. To expedite notice to the applicant, we will use the email address as the primary contact source to update the applicant on the status of their application. It is important to ensure the email address is correct and current at all times.

  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. Cardiopulmonary resuscitation (CPR) Attestation:**
  You must complete a cardiopulmonary resuscitation (CPR) course that included both a written and skills demonstration test. Attach a copy of the front and back of your cardiopulmonary resuscitation (CPR) card or certificate as proof of completion.
- ☐ **3. Continuing Education Attestation:** Required by **WAC 246-72-100**.
- ☐ **4. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

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Washington State Department of HEALTH

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Medical Cannabis Consultant
Expired Certificate Activation Application

Please print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. 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)	☐ Male ☐ Prefer Not to Answer ☐ Female ☐ X

Name	First	Middle	Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (Enter 10 digit #)	Cell (Enter 10 digit #)

Email address

Mailing address (if different from above)

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 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):

2. Cardiopulmonary Resuscitation (CPR) Attestation

I certify that I have completed a Cardiopulmonary Resuscitation (CPR) Course that included both a written and skills demonstration test.

I have attached a copy of my Cardiopulmonary Resuscitation (CPR) Course card or certificate as proof of completion.

Applicant's Initials	Date

3. Continuing Education Attestation

I certify that I have met all continuing education and competency requirements. I understand that I must maintain records of continuing education completion for at least four years.

Applicant's Initials	Date

4. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)

the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- 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.

Dated _____ By:_____

(mm/dd/yyyy) (Original signature of applicant)

RCW/WAC and Online Website Links

RCW/WAC Links

Medical Cannabis Consultant Rules, Chapter 246-72 WAC

Medical Cannabis Consultant Laws, Chapter 69.51A RCW

Online

Medical Cannabis Consultant Web Page