Washington State Department of Health
Medical Assistant Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Hemodialysis Authorized Representative Attestation Form

This must be completed by the person who supervised, trained, or observed you giving direct patient care in a dialysis facility. This person must be a medical doctor (MD), osteopathic doctor DO, advanced registered nurse practitioner with prescriptive authority (ARNP) or registered nurse (RN) licensed in Washington State.

Applicant's Demographics:

First Name	Middle	Last Name

Credential # (If available)	Date of Birth

Address

City	State	Zip Code

To be completed by the authorized representative:

The medical assistant-hemodialysis technician shall receive training, evaluation(s), and assessment of knowledge skills to determine minimum level competency.

I, _____

Representative Name—Type or Print

(Who supervises, trains, or observes student providing direct patient care in a dialysis facility or center)

verify that _____

Hemodialysis Technician Name—Type or Print

completed training in both didactic and supervised clinical instruction, as required by WAC 246-827-0500.

_____ _____

Signature of Authorized Representative — Date

_____ _____

License Number — Expiration Date

Submit completed form with original signatures to the address above.