Radiologist Assistant Expired Certification 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
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Radiologist Assistant Credentialing
PO 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 Renewal Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Pay** Expired Certification 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.
  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 certification. 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 states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

- ☐ **3. Professional 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. Continuing Education Attestation.** Required by **WAC 246-12-040**.
- ☐ **6. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

Washington State Department of HEALTH

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Radiologist Assistant Expired Certification Activation Application

Please print clearly. Follow all instructions provided. It is the responsibility of the applicant to submit all required 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):

2. Other License, Certification, or Registration

List all jurisdictions, including Washington State, in which you hold or have held a license, certification, or registration.

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

3. Professional Experience

List in date order all your professional work experience since your Washington State credential expired. Attach additional pages if you need more space.

Type of experience of practice and location	Start (mm/yyyy)	End (mm/yyyy)

4. Disciplinary Action Attestation

I certify that 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.

APPLICANT'S INITIALS

5. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all classes attended/claimed.

APPLICANT'S INITIALS

6. 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 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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Washington State Department of HEALTH

Radiologist Assistant Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Supervisory Plan

Radiologist Assistant Name: _____

License Number: _____

Telephone Number: _____

Radiologist Assistant Practice Address: _____

City: _____ State: _____ Zip Code: _____

Physician Supervisor: _____

License Number: _____

Board Certification Date: _____

Name of Physician Group: (if applicable) _____

Radiologist Practice Address: (for supervising physician) _____

City: _____ State: _____ Zip Code: _____

The Radiologist Assistant identified above is authorized to assist the following:

☐ All radiologists at my practice location as indicated above.

☐ All radiologists at the following practice location.

(for additional practice locations, please attach a separate 8 1/2 x 11 document listing the required information)

_____
Group Name

_____
Address

_____
City, State, Zip Code

☐ Only the radiologists identified below.
(for additional practice locations, please attach a separate 8 1/2 x 11 document listing the required information)

1. _____
Name License Number

_____
Address

_____
City, State, Zip Code

2. _____
Name License Number

_____
Address

_____
City, State, Zip Code

3. _____
Name License Number

_____
Address

_____
City, State, Zip Code

We, the undersigned, hereby certify under penalty of perjury under the laws of Washington State that the foregoing information in this supervisory plan is correct to the best of our knowledge and belief. We further certify that we have reviewed the current statutes, rules, and regulations of Washington State pertaining to radiologist assistants and understand our duties and responsibilities. We agree that if this supervisory relationship is ended, the supervising radiologist or the radiologist assistant must notify the Department of Health in writing within 60 calendar days.

Signature of Radiologist Assistant	Signature of Supervising Radiologist
Print Name	Print Name
Date	Date

RCW/WAC and Online Websites Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Radiologist Assistant Laws, RCW 18.84

Radiologist Assistant Rules, WAC 246-926

Alternative Education

Alternative Training Requirements, WAC 246-926-110

Online

Radiologist Assistant Program, Web Page