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

Credential Verification

To be completed by the applicant:
Please complete the top section of this form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. Instruct them to send the form directly to the address listed above.

Note: Credentialing agencies may require a fee to verify a license, registration, or certification. Check in advance to help expedite the process.

Applicant Demographics:

First Name	Middle	Last Name
Credential # (If available)	Date of Birth	
I authorize the release of the information below to the Washington State Department of Health. Signature: _____		

To be completed by the regulatory agency:
Please complete this form regarding the applicant listed above. Submit the completed form and any other requested material directly to this office at the address above. We will not accept the form if submitted by the applicant.

Name of license, certification, or registration holder		License, certification, or registration number
Issue Date	Expiration Date	License, certification, or registration status
Method of license, certification, or registration		
Has the individual ever had any disciplinary action in your state? ☐ Yes ☐ No If yes, please attach an explanation and provide a copy of the final order or other documentation of action taken.		

(SEAL)

_____
Signature:

_____
Title:

_____
Name of Regulatory Agency:

_____
Date: