**Section 1: Provider Information**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name |  | Last Name |  |
| Home Phone |  | Mobile Phone |  |
| Email |  | Date of Birth |  |

**Section 2: Address Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Address Line 1 |  | Address Line 2 |  |
| City |  | State/Province |  |
| County of Residence |  | | |
| Zip Code |  | | |

**Section 3: License Information – List All States/Occupations**

**Occupation Information**

|  |  |
| --- | --- |
| Health Professions Occupation |  |
| Professional License Number |  |
| Issuing State |  |

**Occupation Information**

|  |  |
| --- | --- |
| Health Professions Occupation |  |
| Professional License Number |  |
| Issuing State |  |

**Occupation Information**

|  |  |
| --- | --- |
| Health Professions Occupation |  |
| Professional License Number |  |
| Issuing State |  |

**Please return application to:** [**WAserv@doh.wa.gov**](mailto:WAserv@doh.wa.gov)

**Internal Review Section for Department of Health**

**Section 3: Application Review**

|  |  |
| --- | --- |
| Date the Registration received |  |
| Occupation Professional Status |  |
| Signature |  |
| Date added to WAserv |  |

**Log-In Information Assigned**

|  |  |
| --- | --- |
| Organization | **COVID-19** |
| Facility Assignment |  |
| User Name |  |
| Password |  |
| Confirm Password |  |
| Secret Question |  |
| Secret Answer |  |
| Terms of Service Checkbox |  |