Colon Hydrotherapist 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:

Certified Adviser 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

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the forms required.

☐ **Application Fee.** This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **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 on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the 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. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the questions. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. 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.

☐ **4. Education:**
List all of your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

☐ **5. Experience:**
List all of your professional experience and practice from date of graduation from professional college. Attach additional completed pages if you need more space.

☐ **6. Applicant's Attestation:**
You must sign and date this for us to process the application.

☐ **7. National Certification/Registration:**

Individuals applying for certification through national certification or registration as a colon hydrotherapist must attest to being certified or registered through one of the following organizations:

1) Global Professional Association for Colon Hydrotherapy (GPACT);

2) International Association for Colon Hydrotherapy (I-ACT); or

3) National Board for Colon Hydrotherapy (NBCHT).

☐ **8. Training Affiliation Relationship:**

Individuals applying to sit for the Washington State Colon Hydrotherapist examination must establish a training program by filing a Training Affiliation Relationship Registration form.

☐ **9. Training Attestation:**

Upon completion of the registered training program, the trainee and supervising naturopathic physician must submit the training attestation form for the trainee to be approved to sit for the Washington State Colon Hydrotherapist examination.

☐ **10. Affiliation Relationship Registration:**

Once an applicant meets either the national certification/registration or Washington State examination requirements, the colon hydrotherapist may only practice under a registered Affiliation Relationship. There is no limit to the number of affiliation relationships a colon hydrotherapist may have with naturopathic physicians; however, a colon hydrotherapist's certification is considered inoperable when there is no registered affiliation relationship on file.

☐ **11. Examination**

The Washington State examination for colon hydrotherapists are administered by the NBCHT.

The examinations shall be conducted in accordance with the NBCHT security measures and contract.

Applicants taking the state examination must meet the training requirements above and submit the Training Attestation-Request for State Examination form.

Once authorized by the Board of Naturopathy, applicants must contact the NBCHT and complete a NBCHT application prior to be scheduled for the Washington State examination.

Examination candidates will be advised of the results of their examination in writing by the Board of Naturopathy and the NBCHT.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.
Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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Washington State Department of Health

Date Stamp Here

Revenue:

Colon Hydrotherapist Certification Application

Please print clearly. It is the responsibility of the applicant to submit all supporting documentation. Failure to do so may result in a delay in processing your application.

Applying by: ☐ National Certification/Registration ☐ Washington State Examination

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

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. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

3. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional completed pages if you need more space.

State/Jurisdiction	Profession	License Type	License		Method of License	Currently in Force	
			Year Issued	Number		Yes	No
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

4. Education

List all of your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

Full Name, City and State of Schools Attended	Degree Earned	Attendance	
		Start Date	End Date

5. Experience

List all of your professional experience. Exclude activities listed under other sections. Attach additional completed pages if you need more space.

Name and location of institution	From (MM/DD/YYYY)	To (MM/DD/YYYY)	Type of experience or specialty

6. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)
Washington that 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 that 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: _____ in _____
(mm/dd/yyyy) (City, State)

By: _____
(Signature of applicant)

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Washington State Department of Health
Colon Hydrotherapist Credentialing
PO Box 47877
Olympia WA, 98504-7877
360-236-4700
Fax: 360-236-4918

Date Stamp Here

Colon Hydrotherapy National Certification or Registration Attestation Form

To attest to national certification or registration, return this form by mail directly to the Department of Health.

Applicant Demographics

First Name	Middle	Last Name

Credential Number (if applicable)	Date of Birth

Address		

City	State	Zip Code

I hereby attest that I hold the following national credential as a colon hydrotherapist which is substantially equivalent to the education, training, and examination requirements as described in chapter 246-836A WAC:

☐ I-ACT _____ _____
(Registration/Certification Number, if known) Date Issued (mm/dd/yyyy)

☐ GPACT _____ _____
(Registration/Certification Number, if known) Date Issued (mm/dd/yyyy)

☐ NBCHT _____ _____
(Registration/Certification Number, if known) Date Issued (mm/dd/yyyy)

Submit completed form with original signatures to the address above.

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PO Box 47877
Olympia WA, 98504-7877
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Fax: 360-236-4918

Date Stamp Here

Revenue:

Colon Hydrotherapist Registration of Training Affiliation Relationship Form

Please Note: This form must be completed fully. Failure to do so may result in a delay of processing. Mail this signed form to the address above or to EMSCred@doh.wa.gov.

Date	Effective Date of Affiliation Agreement	
Colon Hydrotherapist's Name (please print)	Credential Number (if applicable) XXX.XX._____	
Mailing Address		
City	State	Zip Code
Email Address		
Naturopathic Physician's Name (please print)	Credential Number (if applicable) NATU.NT._____	
Email Address		

The affiliation relationship established through this document between the supervising naturopathic physician and colon hydrotherapist trainee identified above shall include a training schedule for the completion of a minimum of 30 colon hydrotherapy treatment procedures by the trainee within 6 months of the date filed with the Board of Naturopathy or its designee. The supervising naturopathic physician shall provide direct visual supervision for each colon hydrotherapy procedure performed by the colon hydrotherapist trainee.

The supervising naturopathic physician shall ensure the affiliation relationship training schedule allows for the colon hydrotherapist trainee to successfully complete didactic education in:

- The history, theory, and practice of colon hydrotherapy to include risks and contraindications;
- Anatomy and physiology, a portion of which must include the anatomy and physiology of the alimentary tract as well as the function and disfunction of intestinal health;
- Professional ethics and patient boundaries;
- Business ethics and office procedures; and
- Equipment safety, infection prevention and control, and the handling and disposal of used equipment.

Documentation of all colon hydrotherapy training, duties, and responsibilities of the trainee must be completed, signed by the supervising naturopathic physician and the colon hydrotherapy trainee, and placed in the trainee's file. Such documentation shall be retained for a minimum of two years following completion of such training and be made available for inspection upon request by the Board of Naturopathy or its designee.

Responsibility:

The supervising naturopathic physician and colon hydrotherapist trainee are equally responsible for any act performed by the trainee as it relates to the practice of colon hydrotherapy. The training affiliation referenced on this form is valid for 6 months from the date of filing with the Board of Naturopathy or its designee. If the colon hydrotherapist trainee is unable to compete such training within 6 months, the training is null and void, and the supervising naturopathic physician and colon hydrotherapist trainee must initiate a new training affiliation relationship and register it with the Board of Naturopathy or its designee. Supervising naturopathic physicians registering training affiliation relationships are limited to a total of 2 training programs for the same colon hydrotherapist trainee.

Date	
Colon Hydrotherapist Signature	
Naturopathic Physician Signature	

Submit completed form with original signatures to the address above.

Washington State Department of Health
Colon Hydrotherapist Credentialing
PO Box 47877
Olympia WA, 98504-7877
360-236-4700
Fax: 360-236-4918

Date Stamp Here

Colon Hydrotherapist Training Attestation Request for State Examination

Complete this form if you completed a colon hydrotherapy training program supervised by a Washington State licensed naturopathic physician. The naturopathic physician who supervised the colon hydrotherapy training program must sign and date this as proof of completion.

Applicant Demographics

First Name	Middle	Last Name

Credential Number (if applicable)	Date of Birth

Address

City	State	Zip Code

Washington State Licensed Supervising Naturopathic Physician Attestation

The colon hydrotherapist identified above has received education and training, been assessed for knowledge, skills and proficiency, and is determined to meet the minimum level of competency in colon hydrotherapy.

The colon hydrotherapist identified above is also hereby requesting approval to sit for the Washington State examination administered by the NBCHT.

I, _____, hereby attest that _____
(Supervising Naturopathic Physician) (Colon Hydrotherapist name)

has completed the education, training, and practicum requirements in chapter 246-836A WAC.

_____ _____
Signature of Naturopathic Physician Date (mm/dd/yyyy)

_____ _____
License Number Expiration Date (mm/dd/yyyy)

Submit completed form with original signatures to the address above.

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Date Stamp Here

Revenue:

Colon Hydrotherapist Registration of Affiliation Relationship Form

Please Note: This form must be completed fully. Failure to do so may result in a delay of processing. Mail this signed form to the address above or to EMSCred@doh.wa.gov.

Date	Effective Date of Affiliation Agreement	
Colon Hydrotherapist's Name (please print)	Credential Number (if applicable) XXX.XX._____	
Mailing Address		
City	State	Zip Code
Email Address		
Naturopathic Physician's Name (please print)	Credential Number (if applicable) NATU.NT._____	
Email Address		

The affiliation relationship document shall be signed by both practitioners indicated on this form. Copies of this relationship document shall be maintained by all parties and be made available for inspection upon request by the Board of Naturopathy or its designee.

The affiliation relationship document shall include a description of the patient screening process. Such screening shall include contraindications and patient risk, the patient referral process by the naturopathic physician to the colon hydrotherapist, and how the patient's plan of care is documented and coordinated. Unless otherwise stated in the documented care plan, the referral authorization for colon hydrotherapy treatment shall expire six months from the initial referral date but shall not exceed 24 treatments within that timeframe.

The affiliation relationship document shall include standards by which the colon hydrotherapist will communicate issues that require transferring a patient to a higher level of care.

The affiliation relationship document shall include how contact between the colon hydrotherapist and the referring naturopathic physician will be managed. Such contact shall include in person, virtual, or audio-only contact, as well as how such contact shall occur after the working hours of either practitioner.
The affiliation relationship document shall include a description of how the colon hydrotherapy equipment is to be inspected and maintained.
Comments:
Responsibility: The naturopathic physician and colon hydrotherapist are equally responsible for any act performed by the colon hydrotherapist as it relates to the practice of colon hydrotherapy. The affiliation agreement referenced on this form shall continue to be valid until rescinded in writing by either party. The document notifying such rescission must signed, dated, and be filed with the Board of Naturopathy or its designee.

Date	
Colon Hydrotherapist Signature	
Naturopathic Physician Signature	

Submit completed form with original signatures to the address above.

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Colon Hydrotherapy Law, RCW 18.36A

Colon Hydrotherapy Rules, WAC 246-836A

Online

Colon Hydrotherapy, Web Page