



# Physical Therapist or Physical Therapy Assistant License Inactive to Active Application Packet

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## 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.

## 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:**

Physical Therapy  
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](mailto:civil.rights@doh.wa.gov).

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## Application Instructions Checklist

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

- Application Fee. This fee is 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 on your license. 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.**  
In date order, list all your professional work experience since your Washington State credential became inactive. Attach additional pages if you need more space.
- 4. Disciplinary Action Attestation.**  
Required by [WAC 246-12-110](#).
- 5. Continuing Education Attestation.**  
Required by [WAC 246-12-110](#).
- 6. Applicant's Attestation.**  
Required to be both signed and dated in order to process the application.



## License Requirements

If your license has been **Inactive over three years but less than five years:**

- Complete this application and submit the appropriate [fees](#).
- Completion of 32 hours of continuing education for physical therapists or 24 hours of continuing education for physical therapy assistants, and 200 hours of continuing competency within the last two years as shown in [WAC 246-915-085](#).
- Successfully pass the NPTE as provided in [RCW 18.74.035](#). The board may waive reexamination if the physical therapist or physical therapist assistant presents evidence of continuing competency satisfactory to the board.
- Completion of the [Jurisprudence Examination](#). Study the Washington State Physical Therapy Practice Laws [RCW 18.74](#) and [WAC 246-915](#). Once you have successfully completed the examination your electronic results will be submitted to the Department. Please print the results page for your records.

If your license has been **Inactive over five years:**

- Complete this application and submit the appropriate [fees](#).
- Completion of 32 hours of continuing education for physical therapists or 24 hours of continuing education for physical therapy assistants, and 200 hours of continuing competency within the last two years as shown in [WAC 246-915-085](#).
- Successfully retake and pass the NPTE as provided in [RCW 18.74.035](#).
- Completion of the [Jurisprudence Examination](#). Study the Washington State Physical Therapy Practice Laws [RCW 18.74](#) and [WAC 246-915](#). Once you have successfully completed the examination your electronic results will be submitted to the Department. Please print the results page for your records.

If your license is **Inactive but you are currently licensed and actively practicing in another U.S. Jurisdiction:**

- Complete this application and submit the appropriate [fees](#).
- Provide verification of active practice from the U.S. Jurisdiction.
- Provide any additional requirements as requested by the board.
- Completion of the [Jurisprudence Examination](#). Study the Washington State Physical Therapy Practice Laws [RCW 18.74](#) and [WAC 246-915](#). Once you have successfully completed the examination your electronic results will be submitted to the Department. Please print the results page for your records.
- Completion of 32 hours of continuing education for physical therapists or 24 hours of continuing education for physical therapy assistants, and 200 hours of continuing competency within the last two years as shown in [WAC 246-915-085](#).

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## Physical Therapist or Physical Therapy Assistant License Inactive to Active Application

Select One:

- Inactive Over Three Years but Less than Five Years     
  Inactive Over Five Years  
 Inactive Over Three Years but Currently Licensed in another U.S. Jurisdiction

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> X
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Name	First	Middle	Last
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Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address if different from above address of record

City	State	Zip Code	County
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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

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

## 3. Professional Experience

Work Setting and Location	start (mm/yyyy)	end (mm/yyyy)

## 4. Disciplinary Action Attestation

I certify 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	Today's Date
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## 5. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify I have met all continuing education and competency requirements for the past two years.

Applicant's Initials	Date
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## 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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## **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](#)

[Physical Therapy Rules, WAC 246-915](#)

[Physical Therapy Laws, RCW 18.74](#)

### **Online**

[Physical Therapy Board Program, website](#)

[FSBPT, website \(NPTE\)](#)