



Birth Doula Certification 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.

In order to process your request:

Mail completed application and other documents to:

Birth Doula 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 ink. It is your responsibility to submit the correct forms required.

Select one:

- Completed Culturally Congruent Ancestral Practices, Training, and Education and an Approved Birth Doula Education Program
- Completed Culturally Congruent Ancestral Practices, Training, and Education and Ancestral Pathway Competencies
- Out of State Endorsement

- 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 credential. 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 one.

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 question. 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. Culturally Congruent Ancestral Practice, Training, and Education:

List name and address of educational training program, and date of completion.

4. Approved Educational Training Program:

List name and address of educational training program, and date of completion.

5. Ancestral Pathway Competencies Attestation:

Check the yes or no boxes and attest to completing training, and submitting letters of recommendation.

6. Other License, Certification, or Registration:

List all states 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.

7. Applicant’s Attestation:

You must sign and date this for us to process the application.

Certification Requirements

- Complete application
- If you hold a credential in any other state, a license verification must be submitted from each state. [Credential verification form](#).
- Successful completion of culturally congruent ancestral practice's training and education that demonstrates learned familiarity with clients' cultural practices using culturally congruent care related to birth in client communities where the doula may practice. Such training may include, but is not limited to:
 - Birth Justice and Advocacy (history of obstetrics)
 - Erasure of Granny Midwives and Indigenous birthwork
 - LGBTQ+/Gender Inclusive care
 - Black and Indigenous perinatal health crisis
 - Medical racism and advocacy
 - Trauma-informed care
 - Social determinants of health
 - Adverse childhood experiences (ACES)
 - Ancestral Pathway ONLY: Other training and education that enhances the applicant's knowledge of culturally congruent ancestral practices

Documentation of completion must include:

- An attestation that you have successfully completed culturally congruent ancestral practices training and education (section 3 of the application) or,
 - A certificate of completion from a relevant training that lists your name.
- In addition to culturally congruent ancestral practices, training, and education, you must also complete an approved birth doula training program as outlined in [WAC 246-835-020](#) that introduces the key principals of the following topics:
 - Role of a birth doula
 - Prenatal and birth care
 - Postpartum care
 - Communication and interpersonal skills
 - Doula safety and self-care
 - Birth justice and advocacy

Approved programs are listed on our webpage at doh.wa.gov.

Or

- Complete requirements for ancestral pathways competencies that is substantially equivalent to the approved birth doula training program ([WAC 246-835-020](#)). If you completed ancestral pathway competencies, you must submit the following:
 - An attestation that you have completed training that is substantially equivalent to the required training in [WAC 246-835-020](#) (section 5 of the application) and,
 - Three written client testimonial letters of recommendation from profession-related leaders or peers using testimonial templates provided by the department. Letters must be written within the last five years. One letter must be from either a licensed provider, a community-based organization, or a practicing doula or midwife.

Certification by Endorsement

- An initial applicant currently certified to practice as a birth doula in another state, the District of Columbia, or a territory of the United States may be licensed by endorsement. An applicant shall comply with the requirements for licensure as specified in chapters [18.47 RCW](#) and [WAC 246-835](#) and submit proof of:
 - Current certification from another United States jurisdiction; and
 - For applicants who have been certified in another jurisdiction for at least two years, completion of 10 hours of continuing education within the two-year period immediately preceding licensure.

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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Date Stamp Here

Birth Doula Certification Application

Select one:

- Completed Culturally Congruent Ancestral Practices, Training, and Education and an Approved Training Program
- Completed Culturally Congruent Ancestral Practices, Training, and Education and Ancestral Pathway Competencies
- Out of State Endorsement

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 #)
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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. 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. Culturally Congruent Ancestral Practice, Training, and Education

I have successfully completed culturally congruent ancestral practices, training, and education as defined in [WAC 246-835-025](#), which includes culturally congruent care in the birthing client’s community.

Yes No

Applicant's Initials	Today's Date

OR

I have not completed culturally congruent ancestral practices, training, and education and must submit a certificate of completion from a relevant training.

Yes No

4. Approved Educational Training Program

Attendance		Name and Address of Educational Training Program
Start mm/yyyy	End mm/yyyy	

5. Ancestral Pathway Competencies Attestation

I have successfully completed training in Ancestral pathway competencies in [WAC 246-835-022](#) and culturally congruent ancestral practices, training, and education defined in [WAC 246-835-025](#), which includes culturally congruent care in the birthing client's community.

Yes No

AND

I've submitted three written client letters of recommendation from profession-related leaders or peers on forms provided by the department.

Yes No

Applicant's Initials	Today's Date

6. Other License, Certification, Registration

List all states where credentials are or were held. List credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. If you need more space, attach a sheet of paper.

State	Profession	License	License Type	Method of License	Currently in force
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes

7. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state
(Print applicant name clearly)
of 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 _____ at _____
(mm/dd/yyyy) (city/state)

By: _____
(Original signature of applicant)

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Birth Doula Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Birth Doula Certification Letter of Recommendation

Instructions: Three written client testimonial letters or letters of recommendation from profession-related leaders or peers are required. Letters must be completed on this template and written within the last five years. One letter must be from either a licensed provider, a community-based organization, or a practicing birth doula or midwife.

Applicant's Name _____

To be completed by recommender:

I have known the applicant for approximately: _____ years _____ months

My relationship to the applicant was (or is) in the following capacity:

- Peer Client Profession Related Leader Licensed Provider
- Practicing Doula or Midwife

I hereby certify that I am licensed and in good standing in the state of _____.

My license type number is: _____

I further certify that I have been personally acquainted with _____ and that to the best of my knowledge, I believe he or she is of good moral and professional character. I confirm that he or she is free from habits liable to interfere with his or her professional services.

Remarks: _____

Print Name: _____

Street Address or PO Box: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Daytime Phone (enter 10 digit #): _____

Signature: _____ Date: _____



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](#)

[Birth Doulas RCW 18.47](#)

[Birth Doulas WAC 246-835](#)

Online

[Birth Doulas, Washington State Department of Health](#)