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

# Board of Physical Therapy Intramuscular Needling Endorsement Qualified Provider Attestation Form

Send this form to your Qualified Provider to fill out, and return to you. Submit this complete attestation as part of your application. If you have more than one Qualified Provider, please use additional Qualified Provider attestation forms. You may not serve as your own Qualified Provider.

| **Applicant Demographics** | | |
|---|---|---|
| First Name | Middle | Last Name |
| Credential # | | Date of Birth |
| **Qualified Provider Demographics (the qualified provider must fill out the remaining fields)** | | |
| First Name | Middle | Last Name |
| Credential # (if available) | | Email Address |

Please select the option that indicates how you qualify as a qualified provider in accordance with RCW 18.74.200 and WAC 246-915-390.

☐ A physician licensed under chapter 18.74 RCW; an osteopathic physician licensed under chapter 18.57 RCW; a licensed naturopath under chapter 18.36A RCW; a licensed acupuncture or Eastern medicine practitioner under chapter 18.06 RCW; or a licensed advanced registered nurse practitioner under chapter 18.79 RCW;

☐ A physical therapist credentialed to perform intramuscular needling in any branch of the United States armed forces;

State/License Number ______________________

☐ A licensed physical therapist who currently holds an intramuscular needling endorsement in Washington State; or

☐ A physical therapist licensed under the laws of another jursidiction who meets the requirements for obtaining an intramuscular needling endorsement but does not currently hold an endorsement in Washington State.

State/License Number ______________________

## Clinical Review of Applicant

I completed a successful clinical review of _______ (hours) which consisted of _______ (number of intramuscular needling treatment sessions)

Please indicate the total hours of clinical review completed in each category:

_______ (hours) The direct or indirect supervision of intramuscular needling treatment sessions

_______ (hours) Review of chart notes from intramuscular needling treatment sessions

_______ (hours) Oversight of intramuscular needling treatment sessions completed through an internship or apprenticeship

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named in this document.

Qualified Provider Signature: ____________________________________ Date: ______________

If the Qualified Provider has passed away, is incapacitated, or cannot be found, the applicant may submit an attestation/signed letter from another person with knowledge of the Qualified Provider's qualification, knowledge that the clinical supervision took place, and knowledge of how many hours were completed. Persons that might have this kind of knowledge may include the Qualified Provider's supervisor or manager, his or her successor, or the owner of the business where the supervision took place. If such a person cannot be found, the applicant may contact the program to determine if other evidence of supervision is sufficient.