

Pharmacy Technician Portability of Professional Licenses of Members of the Uniformed Services and Their Spouses Application Packet

Contents:

1. 690-392 Contents List/Mailing Information..... 1 page
2. 690-393 Application Instruction Checklist 2 pages
3. 690-394 Pharmacy Technician Portability of Professional Licenses of Members of the Uniformed Services and Their Spouses Application Packet 3 pages
4. RCW/WAC and Online Website Links..... 1 page

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 application and any documentation to:

Pharmacy Quality Assurance Commission Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4986

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 doh.information@doh.wa.gov.

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Application Instructions Checklist

This application is submitted under [Public Law No. 117-333 Section 19](#). You must hold an active Pharmacy Technician License in at least one other state, and any other states in which you hold such a registration, must be in good standing.

1. Demographic Information:

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.

Birth date: Provide the month, day, and year of your birth.

Address: List the address we should use to send any information about your registration. 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. We will use the email address provided as the primary contact source to update you on the status of your application. It is important to ensure your email address is correct and current at all times.

2. Other License, Certification, or Registration: List all states, including Washington, where credentials are, or were held. Attach additional pages if you need more space.

3. Disciplinary Action Attestation: Required to be both initialed and dated in order to process the application.

4. Applicant’s Attestation: Required to be both signed and dated in order to process the application.

Documents to submit with your application should include the following:

- A copy of you or spouse's military orders
OR
- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State; and
- 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.

Additional Information:

You will be contacted if any additional information is needed.

Background
Check
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Date
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Here

Rev 0262010000

Pharmacy Technician Portability of Professional Licenses of Members of the Uniformed Services and Their Spouses Application

Please print clearly and complete all sections. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (SSN)

(If you do not have a SSN, see instructions)

Male Female
 Prefer Not to Answer
 X

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 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

List all states, including Washington, where active credentials are or were held. Attach additional pages if you need more space.

State	Profession	Credential		Permanent or temporary	License received by		Currently in force
		Year issued	Number		Examination	Other	
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. 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.

I am subject to the jurisdiction of the state of Washington and the disciplining authority for my profession under [RCW 18.130.040](#) and that Washington's Uniform Disciplinary Act, chapter [18.130 RCW](#) applies to my practice, including enforcing standards of practice, unprofessional conduct, discipline, and continuing education.

Unless I obtain appropriate licensure in Washington, I must maintain my licenses issued by other states in good standing in order to continue practicing in Washington State.

Applicant's Initials	Date

4. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws
(Print applicant name clearly)

of 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.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(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](#)

[Pharmacy Rules, WAC 246-945](#)

[Pharmacy Laws, RCW 18.64](#)

[Standards of Professional Conduct Rules, WAC 246-16](#)

[Public Law No. 117-333 Section 19](#)

Online

[Pharmacy Quality Assurance Commission, Web Page](#)

Get important information about your credential type by [subscribing to email alerts](#).