Washington State Department of Health
Dental Quality Assurance
Commission Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-Of-State
Credential Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered. Instruct them to return the form directly to the above address. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

Name: Last	First	Middle
Mailing Address		
City	State	Zip Code
Any other names used:		
License, Certification, or Registration Number	Date Issued	

Have the licensing agency return this completed form to the above address.

If you have any questions, please call 360-236-4700.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of license, certification, or registration holder:		
Authority providing verification: (state, name & title)		
Applicant licensed, certified, registered by: Written Examination	Date:	Score:
Name of examination:		
Other Examination	Date:	Score:
Name of examination:		
Is it current? Yes ☐ No	Expiration Date:	
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no", please attach explanation.		
Have they ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ No If "yes", please provide a copy of the final order or other documentation of action taken.		
If this individual has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No		

Signature: _____

(SEAL)

Title: _____

Date: _____