Washington State Department of HEALTH

Physical Therapy Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Verification of Electroneuromyographic Training by a Qualified Provider

Complete section one and forward the verification form to the qualified provider for completion.

Applicant Demographics:

First Name	Middle	Last Name

Credential Number (if available)	Date of Birth

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 my application.

Applicant signature _____ Date _____

To be completed by the postgraduate training program:

A qualified provider includes a physical therapist with board certification in clinical electrophysiology from the American Board of Physical Therapy Specialties, a neurologist or a physiatrist.

The above individual seeks verification of training by a qualified provider to place an electroneuromyographic endorsement on his/her physical therapy license.

Please complete the following:

Qualified Provider's Name	Phone (enter 10 digit #)

Address		

City	State	Zip Code

Provider's License Type and License Number	Date Licensed

Education and Training

A minimum of four hundred hours of electroneuromyographic training is required. Training includes at least two hundred needle EMG studies under direct supervision from a qualified provider.

Hours mentored	Describe the activities mentored

Qualified Provider/Mentor Attestation

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 my application.

Signature _____ Date _____

This form may be duplicated