



Psychology License by Endorsement 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 your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Examining Board of Psychology
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

This application is to be used by the following:

- Psychologists who have been licensed in another state or country for at least two years. To determine if your state is equivalent, see our [equivalent states/countries web page](#). If the state or country has not been reviewed the board will review it at their next meeting.

OR

- Psychologists who are a diplomate in good standing of the American Board of Examiners in Professional Psychology, now the American Board of Professional Psychology (ABPP). If applying by this method, you do not need to complete section five of the application.

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 blue or black ink. It is your responsibility to submit the forms required.

Application Fee. This fee is non-refundable. You can check the online [fee page](#) for current fees.

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 about your license. 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.

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.
- Another jurisdiction means any other country, state, federal territory, or military authority.

3. Other License, Certification, or Registration:

List all states where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current.

4. Professional Certifications:

Please indicate if you are a diplomate in good standing with the American Board of Professional Psychology (ABPP). If using the certification to apply, you must have official documentation sent to the department from the ABPP.

5. Education:

Fill out the date you completed the program, the name and location of the institution granting your doctoral degree, the type of doctoral program (e.g. clinical/counseling, etc.). Official transcripts are required to verify a doctoral degree.

6. Applicant’s Attestation:

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

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required. If your application is incomplete, you will be mailed or emailed a letter regarding the deficiencies.

- You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

Jurisprudence Examination Information

The jurisprudence examination is available online. The examination will be sent electronically to you after you have passed the Examination of Professional Practice in Psychology (EPPP), has completed your experience hours, and have met all requirements to be licensed.

Jurisprudence Examination Topics:

You should know and understand Washington State statutes and rules not limited to, and how they relate to the practice of psychology in this state, including, but not limited to:

[RCW 18.83 Psychology Law](#)

[RCW 18.130 Uniforms Disciplinary Act](#)

[RCW 70.02 Health Care Information Act](#)

[RCW 26.44 Abuse of Children](#)

[RCW 71.05 Mental Illness Act](#)

[RCW 74.34 Abuse of Vulnerable Adults](#)

[WAC 246-15 Whistleblower Complaints](#)

[WAC 246-12 Administrative Procedures & Requirements for Credentialed Health Care Providers](#)

[WAC 246-924 Psychology Rules](#)

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

The Web site for the score transfer information is: <http://www.asppb.org/>

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
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Revenue: 0219010000

Psychologist License by Endorsement Application

Please print clearly. It is the responsibility of the applicant to submit all supporting documentation. Failure to do so may result in a delay in processing your application.

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) | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> 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 #) |
|--------------------------|------------------------|-------------------------|

Email address

Mailing address if different from above address of record

| | | | |
|------|-------|----------|--------|
| City | State | Zip Code | County |
|------|-------|----------|--------|

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.

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

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. Other License, Certification, or Registration

List all jurisdictions where credentials are or were held. Verification is required on the form provided. Attach additional pages if you need more space.

| State or Other Jurisdiction | Permanent or Temporary | License by Written and/or Oral Examination | License | | Currently Active? |
|-----------------------------|------------------------|--|-------------|--------|-------------------|
| | | | Year Issued | Number | |
| | | | | | |
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4. Professional Certification

Are you a diplomate in good standing with the American Board of Professional Psychology?

Yes No

5. Education

Name and location of regionally accredited institution granting doctoral degree

Type of doctoral program (e.g. clinical/counseling, etc.)

Date degree was completed

List in date order the name and location of each college, university, or professional school attended, the time spent in each, and if a graduate, the year of graduation.

| Name and Location of Institution | Dates | | Date Graduated (mm/dd/yy) | Degree Earned | Major Area of Study | # of Semester/ Quarter Hours Earned |
|----------------------------------|--------------------|------------------|------------------------------|------------------|------------------------|---|
| | From (mm/dd/yy) | To (mm/dd/yy) | | | | |
| | | | | | | |
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| | | | | | | |

Was your doctoral degree program APA or CPA accredited? Yes No

Was your doctoral internship APA or APPIC accredited? Yes No

Check your areas of professional competency:

Clinical/Counseling

Neuropsychology

Industrial/Organizational

School/Educational

Other (specify) _____

6. Applicant's Attestation

I _____, declare under penalty of perjury under the laws of the state of
(Name of Applicant)

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.

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 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 _____ By _____
(mm/dd/yyyy) (Original Signature of Applicant)

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Washington State Department of

Health

Board of Psychology Credentialing

P.O. Box 47877

Olympia, WA 98504-7877

360-236-4700

Examining Board of Psychology License 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 held a license/registration/certification. Instruct them to return the form directly to the address listed above. Make a copy of this form if you are licensed in more than one state and/or jurisdiction. Licensing agencies normally charge a fee to verify a license. Please check in advance to help expedite this process.

If you have a license with the Department of Health, you do not need to complete a verification form.

This form is not required of those credentials issued by Washington State.

Name: _____

Mailing Address: _____

City, State and Zip Code: _____

Any other names used: _____

License Number: _____ Date Issued: _____

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

License Verification

(To be Completed by the State Psychology Board)

Please complete this form regarding the applicant listed. 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 licensed psychologist: _____

Authority providing verification: _____

Applicant was licensed by:

Written Examination: _____ Date: _____ Score: _____

Name of Examination: _____

Other Examination: _____ Date: _____ Score: _____

Name of Examination: _____

Is license current? Yes No

Expiration Date: _____ Issuance Date: _____

Is this licensee considered to be in good standing in your state? Yes No

If "No," please attach explanation.

Has this license ever been:

Yes No

Denied

Suspended

Revoked

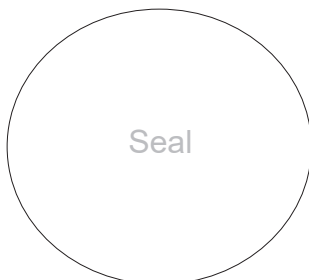
Surrendered

Reinstated

If this licensee has been disciplined, has he/she successfully completed all requirements and is currently in good standing?

Yes No

If yes, please provide a copy of the Final Order or other documentation of action taken.



Signature: _____

Title: _____

Date: _____



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

Employment Verification Form for Psychologist Probationary License

“Probationary license” means a temporary license issued to out-of-state applicants qualifying for licensure reciprocity in Washington state under the restrictions and conditions of [RCW 18.83.170](#) and this chapter.

A person who holds a probationary license may only practice in the relevant profession in a licensed or certified service provider, as defined in [RCW 71.24.025](#).

Applicant's Name and Credential Number (Please Print)

I verify that the above applicant is currently employed or will begin employment with the licensed or certified service provider, as defined in [RCW 71.24.025](#) listed below.

Licensed or Certified Service Provider's Name

Licensed or Certified Service Provider's Physical Address

| | | |
|------|-------|----------|
| City | State | Zip Code |
|------|-------|----------|

Signature of employer

Date MM/DD/YYYY

Send this completed form to the address above.

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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](#)

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

[Psychology Laws, RCW 18.83](#)

[Psychology Rules, WAC 246-924](#)

[Psychology by Endorsement Laws, RCW 18.83.170](#)

Online

[Board of Psychology Web Page](#)

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