Washington State Department of HEALTH

Radiologist Assistant Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Supervisory Plan

Radiologist Assistant Name: _____

License Number: _____

Telephone Number: _____

Radiologist Assistant Practice Address:_____

City: _____ State: _____ Zip Code:_____

Physician Supervisor: _____

License Number:_____

Board Certification Date:_____

Name of Physician Group: (if applicable) _____

Radiologist Practice Address: (for supervising physician)_____

City: _____ State: _____ Zip Code:_____

The Radiologist Assistant identified above is authorized to assist the following:

☐ All radiologists at my practice location as indicated above.

☐ All radiologists at the following practice location.

(for additional practice locations, please attach a separate 8 1/2 x 11 document listing the required information)

_____
Group Name

_____
Address

_____
City, State, Zip Code

☐ Only the radiologists identified below.
(for additional practice locations, please attach a separate 8 1/2 x 11 document listing the required information)

1. _____

Name License Number

_____

Address

_____

City, State, Zip Code

2. _____

Name License Number

_____

Address

_____

City, State, Zip Code

3. _____

Name License Number

_____

Address

_____

City, State, Zip Code

We, the undersigned, hereby certify under penalty of perjury under the laws of Washington State that the foregoing information in this supervisory plan is correct to the best of our knowledge and belief. We further certify that we have reviewed the current statutes, rules, and regulations of Washington State pertaining to radiologist assistants and understand our duties and responsibilities. We agree that if this supervisory relationship is ended, the supervising radiologist or the radiologist assistant must notify the Department of Health in writing within 60 calendar days.

Signature of Radiologist Assistant	Signature of Supervising Radiologist
Print Name	Print Name
Date	Date