Chiropractic Return to Active from Inactive Status Application Packet

Contents:

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 Chiropractic Quality Assurance Commission at 360-236-2822 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:

Chiropractic Commission
P.O. Box 47858
Olympia, WA 98504-7858

Contact us:

360-236-2822

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

You will be notified in writing if further documentation is required.

To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

☐ **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 Chiropractic Quality Assurance Commission at 360-236-2822 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 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. Other License, Certification, or Registration.** List in date order, most recent to later, **all** your credentials you have held since last being credentialed in Washington State. Include your last active license in Washington State. Attach additional pages if you need more space.

☐ **3. Professional Experience.** List in date order, most recent to later, all your professional work experience since your Washington State credential expired. Attach additional pages if you need more space.

☐ **4. Disciplinary Action Attestation.** Required by **WAC 246-12-040**.

☐ **5. Continuing Education Attestation.** Required by **WAC 246-12-040**.

☐ **6. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

Requirements to Return to Active Status

☐ Submit the completed application and fee.

☐ Take and pass the Washington State Jurisprudence examination.

Based on the Commission's review and implementation of 2SHB 1724, the Commission will not require persons who hold a Washington chiropractic license in "inactive" status seeking to return to "active" status, to take and successfully pass the Commission's jurisprudence examination if the "inactive" license holder holds an active credential in another state, territory of the United States, the District of Columbia, Puerto Rico, or province of Canada that the Commission has recognized as having substantially equivalent standards to those of RCW 18.25.

After conducting a thorough review, the Commission has determined that the licensing requirements of all states of the United States, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands are "substantially equivalent" to those of chapter 18.25 RCW and 246-808 WAC.

If you **do not** hold an active credential in in another state, territory of the United States, the District of Columbia, Puerto Rico, or province of Canada that the Commission has recognized as having substantially equivalent standards, then you will be required to take and pass the Commission's Jurisprudence Examination.

The JP exam fee is $100.

After all documents have been received and the application is complete, the jurisprudence examination will be mailed. You will have 30 days from the date of receipt to complete and return the following:

- Examination booklet
- Answer sheet
- Comment sheet

You must obtain a minimum score of 95 percent as required under WAC 246-808-115.

☐ Out-of-state verification form completed by each state(s) in which you hold or have held a credential/registration/license. The state will complete its portion of the verification form and mail it directly to the Chiropractic Commission.

Washington State Department of HEALTH

Date Stamp Here

Revenue: 0252020000

Chiropractic Return to Active Status from Inactive Status License Activation Application

Please print clearly. Follow all instructions provided. It is the responsibility of the applicant to submit all required supporting documentation. 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)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ 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)

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 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 credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. 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	
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No

3. Professional Experience

Type of Experience of practice and location	Start (mm/yyyy)	End (mm/yyyy)

4. 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.

Applicant's Initials	Date

5. Continuing Education/Continuing Competency Attestation

I certify that I have met all continuing education and competency requirements for the past two years.

Applicant's Initials	Date

6. Applicant's Attestation

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

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 _____ 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

Chiropractic Laws, RCW 18.25

Chiropractic Rules, WAC 246-808

Online

Chiropractic Quality Assurance Commission, Web Page