



# Athletic Trainer Expired License Activation 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:**

Athletic Trainer 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](mailto:civil.rights@doh.wa.gov).

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## Application Instructions Checklist

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

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

**Pay** Late Renewal Penalty Fee.

**Pay** Current Renewal Fee.

**Pay** Expired License Reactivation Fee.

**All fees are non-refundable.** You can check the [fee page](#) for current fees.

**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 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. Email is the Department’s primary form of communication. Please ensure you are checking your spam folders for correspondence.

**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** credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. Attach additional pages if you need more space.
- 3. 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. Continuing Education Attestation.** Required by [WAC 246-12-040](#).
- 5. Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- 6. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

Date  
Stamp  
Here

Revenue 0299050000

**Athletic Trainer Expired License Activation Application**

Please print clearly in ink. Follow all instructions provided. 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.

**1. Demographic Information**

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/> X
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Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address:

Mailing address if different from above address of record

City	State	Zip Code	County
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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. Other License, Certification, or Registration

State/Jurisdiction	Profession	Credential			Method of Licensure	Currently in force	
		Type	Number	Year Issued		No	Yes

## 3. Professional Experience

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

## 4. Continuing Education Attestation

I certify I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all classes attended/claimed.

Applicant's Initials	Date

## 5. 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
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## 6. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of  
(Print applicant name clearly)  
the state of Washington that 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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## 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 as a healthcare provider.

Name: Last	First	Middle	
Mailing Address			
City		State	Zip Code
Phone (enter 10 digit #)		Cell (enter 10 digit #)	
Email address			
Any other names used:			
Washington State healthcare credential type you are applying for:			
Washington State healthcare credential number (if available):		Date Issued	

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

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

This form may be duplicated.

**(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)		
Type of healthcare license, certification or registration:		
Healthcare license, certification or registration number:		
Applicant was credentialed by: <input type="checkbox"/> Written Examination	Date:	Score:
Name of examination:		
<input type="checkbox"/> Other Examination	Date:	Score:
Name of examination:		
Is credential current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration Date:	
Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," please attach explanation.		
Has this credential ever been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No Suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No Revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No Surrendered? <input type="checkbox"/> Yes <input type="checkbox"/> No Reinstated? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

(SEAL)

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Title:

\_\_\_\_\_  
Date:



## **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](#)

[Athletic Trainer Law, RCW 18.250](#)

[Athletic Trainer Rules, WAC 246-916](#)

### **Online**

[Athletic Trainer Program, Web Page](#)

[Board of Certification for Athletic Trainers \(BOC\), http://www.bocatc.org](http://www.bocatc.org)

[Commission of Accreditation of Athletic Training Education \(CAATE\), http://www.caate.net/](http://www.caate.net/)

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