Washington State Department of Health
Dental Quality Assurance Commission
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Proof of Practice

Demographics:		
Name First Middle Last		
Washington Credential #, if applicable	Date of Birth	
Address		
City	State	Zip Code

Location of Practice:

If you have been at the location listed for less than four years, attach an additional sheet of paper, listing other practice locations.

☐ I certify that I am in the practice of dentistry at the following location, I further certify I have practiced dentistry, as defined in RCW 18.32.020, for at least a minimum of twenty hours per week for the four years proceeding this application in another U.S. State or territory.

Address: _____

City: _____ State: _____ Zip Code:_____

From _____ to _____
(mm/yyyy) (mm/yyyy)

Federal Tax No. _____ State Tax No. _____

☐ I certify that I am a dentist serving in the United States federal services. I will submit a letter from my commanding officer outlining my duties, length of service and whether any adverse actions have been reported or taken.

☐ I certify that I am a dentist employed by a dental school, I will submit documentation from the dean or the appropriate administrator of the institution regarding the length, terms of employment, responsibilities and any adverse actions or restrictions.

☐ I certify that I am a dentist in a dental residency program, I will submit documentation from the director or the appropriate administrator of the residency program regarding the length of the residency, duties and responsibilities and any adverse actions or restrictions.

Applicant's Signature _____ Date _____