



Dentistry Expired License (over 3 years) Activation Application Packet

Contents:

- 1. 646-169..... Contents List/SSN Information/Mailing Information 1 page
- 2. 646-170..... Application Instructions Checklist..... 2 pages
- 3. 646-171..... License Requirements 2 pages
- 4. 646-172..... Dental Expired License (over 3 years) Activation Application 5 pages
- 5. 646-125..... Location of Practice 1 page
- 6. 646-129..... DEA Authorization 1 page
- 7. RCW/WAC and Online Web Site Links..... 1 page

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:

Dental Quality Assurance Commission
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

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 required forms.

- Pay Late Renewal Fee.**
- Pay Current Renewal Fee.**
- Pay Expired License Activation Fee. All fees are non-refundable.** You can check the online [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, date and year of your birth.

Address: List the address we should use to send any information about your credential. 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. 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. Professional Training and Experience:

Please list in date order all professional work experience. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. Attach additional pages if you need more space.

4. Other License, Certification, or Registration:

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the [Verification Form](#) and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

5. Disciplinary Action Attestation. Required by [WAC 246-12-040](#).

6. Continuing Education Attestation. Required by [WAC 246-12-040](#).

7. Applicant’s Photograph:

Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and a front view. Your application will not be processed without a current photograph.

8. Applicant’s Attestation. You must sign and date this for us to process the application.

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

- The application is considered incomplete if requested information is left blank. State N/A or place a line through section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See [WAC 246-12-020 \(3\)](#).
- You will receive a courtesy renewal notice if your address of record is kept up to date. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

License Requirements

Additional Information and Instructions

Thank you for applying to activate your dentistry license in Washington State. To expedite the license process, ensure the following information has been included with your application.

- If your Washington State dentist license has been expired for more than three years and you have not been actively practicing in another United States jurisdiction, proof of successful completion of a practical/practice examination is required according to [WAC 246-817-120](#); or a qualifying postgraduate residency program, approved by or administered under the direction of the Dental Quality Assurance Commission.
- Proof of the following is required. If you would like the department to obtain your original application file for this information, please indicate this in a separate cover letter.
 - National Board Scores (Part I and II)
 - Practical/Clinical Examination Score. [WAC 246-817-120](#).
 - Transcript from a Commission on Dental Accreditation (CODA) dental school.
- Location of Practice**
This information is necessary to verify your practice history and should correspond with the chronology portion of your application. Indicate if you are in the military.
- Jurisprudence Examination**
Complete the [online examination](#). Print and send your certificate of completion with your application. It is a multiple choice exam and designed to familiarize you with the Washington State dentistry laws. Current laws can be found [here](#).

The following require you to verify the primary source, they will only be accepted when mailed directly to the department from the source. These items should not be included with your application. They should be sent to:

Dental Quality Assurance Commission
Credentialing
PO Box 47877
Olympia, WA 98504-7877.

- DEA**
Complete this form if you have ever had a DEA number and submit it directly to the Drug Enforcement Administration in Seattle. To contact the Seattle DEA, call 1-888-219-1418. (Form enclosed) If you have not had a DEA number please send a statement to indicate that.

License Verifications

License verifications must be requested by the applicant and submitted directly from every state.

Note: Many states charge a verification processing fee. Contact them prior to request to prevent delays in processing.

Malpractice Clearance

You must have malpractice carriers submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted. If coverage is provided via an umbrella policy through a school, or if you are practicing in the military, please indicate in writing.

Military/Commanding Officer Letter

If you are on active duty in the military, a letter must be submitted from the commanding officer outlining duties, length of service, and whether any adverse actions have been reported or taken.

Note: You cannot practice dentistry until your license is activated.

Date
Stamp
Here

Revenue 0251030000

Dentist Expired License (over 3 years) Activation Application

Please print clearly in ink. Follow the instructions provided. It is the responsibility of the applicant to submit or request 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)	<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
------	-------	----------	--------

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)

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)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s):

Will documents be received in another name? <input type="checkbox"/> Yes <input type="checkbox"/> 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, mental retardation, 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 (cont.)

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. Training and Experience

List in date order all of your professional training and experience including college or university pre-dental program, technical or professional school and practice pertaining to the profession you are applying for. Include all periods of time from the date of graduation to present. You do not have to list continuing education courses. Attach additional pages if you need more space.

Dates		Name and address of institute, place of practice.	Degree/certificate and date received Nature of experience or specialty
From (mm/dd/yyyy)	To (mm/dd/yyyy)		

4. 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. Attach additional pages if you need more space.

State	Profession	Certificate		Permanent or Temporary	License received by		Currently in force
		Year issued	Number		Examination	Other	
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes

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. Continuing Education/Continuing Competency Attestation

I certify I have met all continuing education and competency requirements for the past two years, 42 hours. I am enclosing documentation on all classes attended/claimed.

Applicant's Initials	Date
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7. Applicant's Photograph

Photo Here



Attach Current Photograph Here.
Indicate Date Taken and Sign in
Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

8. 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 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 that 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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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 _____

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Washington State Department of

Health

Dental Quality Assurance Commission
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

DEA Authorization

To the Applicant: Fill out this form if licensed in another state.

Please complete the identifying information and submit this form directly to:

Drug Enforcement Administration
Attention: Edie—Diversion Unit
300 5th Ave Ste 1300
Seattle, WA 98104

Date: _____

To Whom It May Concern:

I am applying for a license to practice dentistry in the state of Washington. Please send this form directly to the Dental Quality Assurance Commission Credentialing.

Thank you for your assistance.

Name: _____

Date of birth: _____

DEA Registration Number: _____

Address where DEA number is registered: _____

Applicant's signature _____

Please print name: _____

To be completed by the Drug Enforcement Administration:

Response: _____

Applicant has surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted, or denied. Yes No

Please mail this completed form to the Dental Quality Assurance Commission Credentialing Section at the address listed above, or you can fax it directly to 360-236-4918.

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RCW/WAC and Online Web Site Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

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

[Dental Professionals Laws, RCW 18.260](#)

[Dentistry Rules, WAC 246-817](#)

[Dentistry Laws, RCW 18.32](#)

Online

[Dental Quality Assurance Commission, Web page](#)

[Drug Enforcement Administration \(DEA\), \[www.deadiversion.usdoj.gov\]\(http://www.deadiversion.usdoj.gov\)](#)

[Washington State Dental Association, \[www.wsda.org/\]\(http://www.wsda.org/\)](#)

[American Dental Association \(ADA\), \[www.ada.org/\]\(http://www.ada.org/\)](#)

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

Required Continuing Education

Continuing education (CE) Training after license has been issued, [WAC 246-817-440](#)