



Washington State Department of  
**Health**

Naturopathic Physician Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877  
360-236-4700

## Intravenous Therapy Attestation Authorization

I attest and affirm that I have (choose one):

- Completed sixteen hours of training during the course of naturopathic medicine instruction at the board approved naturopathic medical school listed below.

Please indicate the naturopathic medical school, and year of graduation. Please print clearly.

Name of School \_\_\_\_\_

Year Graduated \_\_\_\_\_

- Completed sixteen hours of an extended/continuing education course, of which at least eight hours were graduate level training, sponsored by a school approved under chapter [18.36a](#), [18.71](#), [18.57](#), or [18.79 RCW](#).

List the Name and address of institution. Please print clearly. Must be a school approved under chapter [18.36a](#), [18.71](#), [18.57](#), or [18.79 RCW](#).

\_\_\_\_\_  
\_\_\_\_\_

The instruction sponsored by the school listed above that was titled \_\_\_\_\_ and completed on \_\_\_\_\_, included indications, contraindications, formularies, emergency protocols, osmolarity calculation, aseptic technique, and proper documentation.

I further affirm, in accordance with [WAC 246-836-220](#), I will retain training documentation for at least five years from the date of this attestation. I understand failure to give this documentation upon request may result in disciplinary action against my license.

Print Practitioner's name: \_\_\_\_\_

Practitioner's signature: \_\_\_\_\_ Date: \_\_\_\_\_

License Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**For Office Use Only:**

Approved  Disapproved: \_\_\_\_\_ Review Date: \_\_\_\_\_

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