Washington State Department of Health
Naturopathic Physician Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Controlled Substances, Limited to Codeine and Testosterone Products Authorization

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

☐ An active, unencumbered DEA registration in another state.

List the registration number_____

☐ Completed at least four 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 at least four hours of an extended/continuing education course 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

was completed on _____, included principles of medication selection; patient selection and therapeutics education; problem identification and assessment; knowledge of interactions, if any; evaluation of outcome; recognition and management of complications and untoward reactions; and education in pain management and drug seeking behaviors.

I further affirm that, in accordance with **WAC 246-836-211**, 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: _____License Number: _____

Practitioner's signature: _____ Date: _____

Address: _____

City:_____State:_____Zip Code:_____

For Office Use Only:

☐ Approved ☐ Disapproved: _____ Review Date: _____

Signature: _____