Medical Assistant-Registered 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:

Medical Assistant 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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Washington State Department of Health

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.

If you are applying for an initial registration you must pay the application fee. **(This fee is non-refundable).** You can check the online fee page for current fees.

If you are applying for an expired registration reissuance you must pay the following:

- ☐ **Pay** Application Fee.
- ☐ **Pay** Late Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Check if either apply:**
  Request for Military Training and Experience Evaluation
  Spouse or Registered Domestic Partner of Military Personnel
- ☐ **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 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 you were born.

  Address: List the address we should use to send any information about your registration. 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 practicethe essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must provide the documentation listed in the note after the questions. 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 obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Experience:**
List in date order your professional work experience. Attach additional completed pages if you need more space.

☐ **4. Other License, Certification, or Registration:**
List all states where you hold or have held a credential.

☐ **5. Qualifications and Training Attestation:**
You must meet the Qualification and Training Requirements. You must sign and date this as proof of completion.

☐ **6. Applicant Attestation and Signature:**
You must sign and date this for us to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

For Current and Former Servicemembers Requesting Evaluation of Military Training and Experience

Under state law, your military education, training, and experience may count towards attaining certain civilian health care profession credentials in Washington State.

Submitted information will be reviewed by the Department of Health to determine substantial equivalency for meeting the credentialing requirements in this state.

Documents to submit with your health care professional credential application should include the following:

- If applicable, a copy of your DD214 Certificate of Release or Discharge from Active Duty, Member-4 or service 2 copy, or NGB-22 for National Guard.

  Please note:
  - A copy of your DD214 can be downloaded from the **EBenefits website**.
  - You can request a replacement copy of your NGB-22 on the **National Archives website**.
- Official Joint Service Transcript (JST) or Community College of the Air Force(CCAF) Transcripts.

  Please note:
  - JST can be sent electronically by visiting the **JST website** and selecting Washington State Department of Health.
  - CCAF transcripts cannot be sent electronically. See the **CCAF website** for transcript information.
- Verification of Military Experience and Training (VMET) or DD Form 2586. See the **DoDTAP website**.
- If applicable, application for the Evaluation of Learning Experiences During Military Service (DD Form 295). See the **Military Resources website**.

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Washington State Department of Health

Credentialing Requirements

Thank you for applying to become a medical assistant-registered in Washington State.

An application for registration as a medical assistant-registered who applies to the department within seven days of employment by the endorsing Healthcare practitioner, clinic or group practice may work as a medical assistant-registered for up to sixty days while the application is processed.

Note: The applicant must stop working on the sixtieth day of employment if the registration has not been granted for any reason.

In order to qualify for registration you must complete the following:

- [ ] Complete and submit the application, with a original signature, date, and **fee**.
- [ ] Sign and date the application as proof of:
  - Completion of high school education or its equivalent.
  - The ability to read, write, and converse in the English language.
- [ ] Experience:
  List in date order your professional work experience. Attach additional completed pages if you need more space.
- [ ] A medical assistant-registration may be issued if you have a current endorsement from a healthcare practitioner, clinic, or group practice.

  In order to be endorsed, you must:
  - Have a current **endorsement** to perform specific medical tasks signed by a healthcare practitioner or representative of a clinic or group practice filed with the department. You may only perform the medical tasks listed in your current attestation for endorsement.
  - Your endorsement is valid as long as you are continuously employed as a medical assistant-registered by the same Healthcare practitioner, clinic, or group practice and you renew your registration.
  - Your registration based on an endorsement by a healthcare practitioner, clinic, or group practice is not transferable to another healthcare practitioner, clinic, or group practice.
- [ ] **Out-of-State Credential Verification** form sent to each state where you hold or have held a credential. The state will complete its portion of the verification form and mail it directly back to Washington State.

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Medical Assistant Credentialing
P.O. Box 1099
Olympia, WA 98507-1099

Date Stamp Here

Revenue: 0252625081

Medical Assistant-Registered Credential Application

Please print clearly. 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.

Select if either apply:
- ☐ Request for Military Training and Experience Evaluation
- ☐ Spouse or Registered Domestic Partner of Military Personnel

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)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name	First	Middle	Last

Birth date (mm/dd/yyyy)

Address	City

State	Zip Code	County

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email Address

Have you ever been known under any other name(s)?
If yes, list name(s):

Will documents be received in another name?
If yes, list name(s):

Facility Information

Facility Name

Facility Mailing Address

City	State
Zip Code	County

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, intellectual disabilities, 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 Healthcare 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.

   If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

   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 Healthcare 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 Healthcare 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 Healthcare 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 your professional work experience. Attach additional pages if you need more space.

Full Name, City and State/Schools Attended	Degree Earned	Attendance	
		Entrance Date	Ending Date

4. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held.

State/Jurisdiction	Credential Type	Credential		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grandparented

5. Qualifications and Training Attestation

I certify I have completed each of the requirements below.

- A high school diploma or equivalent;
- The ability to read, write, and converse in the English language.

Applicant's Initials	Date

6. Applicant's Attestation

I, ____, declare under penalty of perjury under the laws of the
(Name of Applicant)

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 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 Healthcare. 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 ______________________________ By: ____
(mm/dd/yyyy) (Original Signature of Applicant)

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Medical Assistant Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Medical Assistant-Registered Healthcare Practitioner Endorsement

Applicant:

Use this form for medical assistant-registered endorsement. All information should be printed clearly in blue or black ink. This form may be duplicated.

An endorsement must be signed by a healthcare practitioner as defined in **RCW 18.360.010**.

- You may only perform the medical tasks listed in your current attestation for endorsement, as listed in **RCW 18.360.050(4)**. Do not add additional tasks to this form.
- A new endorsement form must be submitted within 30 days if your tasks change.
- Your endorsement is valid as long as you are continuously employed as a medical assistant-registered by the same healthcare practitioner, clinic or group and you renew your registration.
- Your endorsement is not transferable to another healthcare practitioner, clinic or group practice.

Fill out section one and forward to the healthcare practitioner for completion of sections two through four.

1. Print clearly:		
Name Last	First	Middle
Birth Date (mm/dd/yyyy)	Social Security Number	
Address		
City	State	Zip Code

2. Healthcare Practitioner:

Applicant Date of Hire: ______________________________
(mm/dd/yyyy)

The above individual seeks verification of supervised medical assisting and endorsement as a medical assistant-registered. Please complete the following:

Healthcare Practitioner (check all that apply)

☐ MD ☐ DO ☐ MD-PA ☐ DO-PA ☐ ARNP ☐ RN ☐ DPM ☐ ND ☐ OD

Healthcare Practitioner Name	Phone (enter 10 digit #)
Healthcare Practitioner License Number	License Expiration Date

Practice Setting (Check One):

☐ Group Practice ☐ Clinic ☐ Physician's Office ☐ Hospital ☐ Other Healthcare Facility

3. Facility Information:		
Facility Name		
Facility Mailing Address		
City	State	Zip Code

4. Healthcare Practitioner Attestation:

I____ attest that
Healthcare Practitioner (print)

____ will assist
Medical Assistant-Registered Name (print)

with patient care and perform administrative and clinical procedures.

I attest appropriate supervision will be provided to the medical assistant-registered in carrying out the procedures delegated.

I attest the medical assistant-registered has demonstrated competency to perform the following tasks:

	Yes	No
a. Fundamental procedures:		
i. Wrapping items for autoclaving	☐	☐
ii. Procedures for sterilizing equipment and instruments	☐	☐
iii. Disposing of biohazardous materials	☐	☐
iv. Practicing standard precautions	☐	☐
b. Clinical procedures:		
i. Preparing for sterile procedures	☐	☐
ii. Taking vital signs	☐	☐
iii. Preparing patients for examination	☐	☐
iv. Observing and reporting patients' signs or symptoms.	☐	☐
c. Specimen collection:		
i. Obtaining specimens for microbiological testing	☐	☐
ii. Instructing patients in proper technique to collect urine and fecal specimens.	☐	☐
iii. Finger and/or heel stick to collect a blood specimen	☐	☐

d. Patient care:

i. Telephone and in-person screening limited to intake and gathering of information without requiring the exercise of judgment based on clinical knowledge ☐ ☐

ii. Obtaining vital signs ☐ ☐

iii. Obtaining and recording patient history ☐ ☐

iv. Preparing and maintaining examination and treatment areas ☐ ☐

v. Preparing patients for and assisting with routine and specialty examinations, procedures, treatments, and minor office surgeries utilizing no more than local anesthetic. ☐ ☐

vi. Maintaining medical and immunization records ☐ ☐

vii. Screening and following up on test results as directed by a healthcare practitioner ☐ ☐

e. i. Tests waived under the federal clinical laboratory improvement (CLIA) amendments program ☐ ☐

ii. Moderate complexity tests if the medical assistant-registered meets standards for personnel qualifications and responsibilities in compliance with federal regulation for nonwaived testing. ☐ ☐

f. Administering eye drops, topical ointments, and vaccines, including combination or multidose vaccines. ☐ ☐

g. Urethral catheterization when appropriately trained ☐ ☐

I attest that the above information is accurate and complete to the best of my knowledge.
I understand that the Department of Health may request additional information, if it is needed.

Original Signature—Healthcare practitioner	Date (mm/dd/yyyy)
Original Signature—Medical Assistant-Registered	Date (mm/dd/yyyy)

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Medical Assistant Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

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. Instruct them to return the form directly to the address listed above. Licensing agencies normally charge a fee to verify a credential, please check in advance to help expedite this process.

Name: Last		First	Middle
Mailing Address			
City	State	Zip Code	
Any other names used:			
Credential Number		Date Issued	

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

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 credential holder:		
Authority providing verification: (state, name, and title)		
Applicant was credentialed by: ☐ Written Examination	Date:	Score:
Name of examination:		
☐ Other Examination	Date:	Score:
Name of examination:		
Is credential current: ☐ Yes ☐ No	Expiration Date:	
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no", please attach explanation.		
Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ 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? ☐ Yes ☐ 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

Medical Assistant Law, RCW 18.360

Medical Assistant Rules, WAC 246-827

Online

Medical Assistant, Web Page

Get important information about your credential type by **subscribing to email alerts**.