Washington State Department of Health
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)