Podiatric Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Hospital Investigative Letter

Name of applicant (please print):	Birth date (mm/dd/yyyy):

I have applied for a license to practice podiatric medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my hospital privileges and return it the address listed above.

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Podiatric Medical Board.

Signature of Applicant:	Date (mm/dd/yyyy):

1. Does the applicant have, or has he/she ever had, admitting or specialty privileges at your hospital?

☐ Yes ☐ No Beginning Date: Ending Date:

2. Have the applicant's privileges ever been restricted, suspended or revoked by the medical staff or administration, or has he/she ever been asked to resign? ☐ Yes ☐ No If so, for what reason?

3. Has the applicant ever been asked to resign or surrender any privileges voluntarily in lieu of action being taken?
☐ Yes ☐ No If so, for what reason?

4. Is there any information in your files that could call into question the applicant's ability to safely practice Podiatric medicine and surgery? ☐ Yes ☐ No If yes, explain.

Please attach any copies of information in your records that would provide further information.

Name	Title
Facility	Phone (enter 10 digit #)
Address	
Authorized Signature	Date