Agency Affiliated Counselor Expired Registration Activation Application Packet

Contents:

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:

Agency Affiliated Counselor
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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Application Instructions Checklist

You will be notified in writing if further documentation is required.

To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay** Late Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Pay** Expired Registration Reissuance Fee.
  All fees are non-refundable. You can check the online **fee page** for current fees.
- ☐ **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 the 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 of your birth.

  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. Previous Credentialing.** List in date order, most recent to later, **all** your credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. Attach additional completed pages if you need more space.

☐ **3. Professional Experience.** List in date order, most recent to later, all your professional work experience since your Washington State credential expired. Attach additional completed pages if you need more space.

☐ **4. Counseling Services:**
Provide what type of counseling services you will be engaging in.
RCW 18.19.020(6)— Counseling means employing any therapeutic techniques, including but not limited to social work, mental health counseling, marriage and family therapy, and hypnotherapy, for a fee that offer, assist or attempt to assist an individual or individuals in the amelioration or adjustment of mental, emotional, or behavioral problems, and includes therapeutic techniques to achieve sensitivity and awareness of self and others and the development of human potential. For the purposes of this chapter, nothing may be construed to imply that the practice of hypnotherapy is necessarily limited to counseling.

☐ **5. Disciplinary Action Attestation.** Required by **WAC 246-12-040**.

☐ **6. Attestation of Recovery.** Required if practicing as a peer counselor.

☐ **7. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

Agency Affiliated Counselor
Credentialing
P.O. Box 1099
Olympia, WA 98507-1099

Date Stamp Here

Revenue 0207070000

Agency Affiliated Counselor Expired Registration Activation Application

Please print clearly in ink. Follow the instructions provided. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

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

Country

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

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

2. Previous Credentialing

List in date order, most recent to later, **all** your credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. Attach additional completed pages if you need more space.

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently in force	
		Type	Number	Yr Issued		No	Yes

3. Professional Experience

In date order, most recent to later, list all your professional work experience since your Washington State credential expired. Attach additional completed pages if you need more space.

Type of experience of practice and location	Start (mm/yyyy)	End (mm/yyyy)

4. Counseling Services

Will you be practicing as a peer counselor at an agency? Yes ☐ No ☐

Give a brief description of your therapeutic orientation, discipline, theory, or technique.

5. Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

Applicant's Initials	Today's Date

6. Attestation of Recovery

Recovery as defined in RCW 18.205.020(9), means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery often involves achieving remission from active substance use disorder.

☐ I have been in recovery since _____;
(mm/dd/yyyy)

☐ I do not have a substance use disorder.

Applicant's Initials	Date

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the 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 health care. 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) (Signature of applicant)

Agency Affiliated Counselor Credentialing
PO 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 credentialed. Instruct them to return the form directly to the address listed below. Make a copy of this form if you are or have been credentialed in more than one state and/or jurisdiction. Credentialing 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 above address.

Please call 360-236-4700 if you have questions regarding this form.

Out-of-State
Credential Verification Cont.

(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 & 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

School Seal

_____
Signature:

_____
Title:

_____
Date:

Agency Affiliated Counselor Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Agency Affiliated Counselor Employment/Student Verification Form

"Agency affiliated counselor" means a person registered under this chapter who is engaged in counseling and employed by an agency or is a student intern, as defined by the department, who is supervised by agency staff.

"Agency affiliated counselor" includes juvenile probation counselors who are employees of the juvenile court under RCW 13.04.035 and 13.04.040 and juvenile court employees providing functional family therapy, aggression replacement training, or other evidence-based programs approved by the department of children, youth, and families.

Type of Agency Affiliated Counselor:

Mark All That Apply: ☐ Employee ☐ Juvenile Probation Counselor ☐ Student Intern

Check One: ☐ New Agency ☐ Update / Change Agency ☐ Additional Agency

Applicants may not provide unsupervised counseling prior to completion of a criminal background check performed by either the employer or the Department of Health.

Agency affiliated counselors shall notify the department if they are either no longer employed by the agency identified on their application or are now employed with another agency, or both. See RCW 18.19.210.

_____ _____

Agency Affiliated Applicant Name and Credential Number (Please Print) Date of Hire (MM/DD/YYYY)

I verify that the above applicant is currently employed or will begin employment with the agency listed below as required by **WAC 246-810-015**.

_____

Agency or Facility Employer Name

_____

Agency or Facility Physical Address

_____

City State Zip Code

My Agency is a county, state agency, federally recognized Indian tribe located within Washington State or has been recognized by the Secretary of Health to be able to employ agency affiliated counselors.
See **WAC 246-810-016** and **WAC 246-810-015**. Please see the **approved agency affiliated list**.

_____

Signature of employer or designated/authorized employee Date MM/DD/YYYY

Send this completed form to the address above.

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Agency Affiliated Counselor Laws, RCW 18.19

Agency Affiliated Counselor Rules, WAC 246-810

Online

Agency Affiliated Counselor Program, Web Page

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