



Acupuncturist or Acupuncture and Eastern Medicine Practitioner License 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:

Acupuncturist or Acupuncture and Eastern Medicine Practitioner 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

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 ink. It is your responsibility to submit the correct required forms.

Application Fee. This fee is non-refundable. You can check the [fee page](#) for current fees.

Select if the following applies:
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 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 on your license. 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 practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. 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 get 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. Pre-Acupuncture or Eastern Medicine (Basic Science) Education:

Provide a chronological listing of your educational preparation and post-graduate training. Transcripts must be sent directly to the department. Attach an additional page if you need more space.

4. Certified Acupuncture or Eastern Medicine Didactic and Clinical Program:

List the name and address of Acupuncture or Eastern Medicine Didactic and Clinical Program. If you need more space, attach a sheet of paper.

5. Experience:

List in date order all professional experience and practice from date of graduation from professional college. Attach an additional page if you need more space.

6. Other License, Certification, or Registration:

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the [Verification Form](#) and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

7. Applicant’s Attestation:

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 service member 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.

Note: Electronic signatures and/or initials are not accepted.

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License Requirements

- Education Completed Form.** Each course must be listed on the form. It must be completed and sent with the application.
- CPR certification.** A copy of your unexpired Cardio-Pulmonary Resuscitation (CPR) card.

The following require primary source verification. They will only be accepted when mailed directly to the department from the source. These items should not be included with your application. They should be sent directly to the Department of Health, Acupuncturist or Acupuncture and Eastern Medicine Practitioner Credentialing, P.O. Box 47877, Olympia, WA 98504-7877.

- Official transcript.** The transcripts must be for all Basic Science and Eastern Medicine school/educational programs.

If a graduate of a foreign school, provide a credentialing evaluation report from the International Consultants of Delaware (ICD) <http://www.icdeval.com/>

- Verification of clinical training.** The clinical training form must be completed by the approved Acupuncture or Eastern Medicine school verifying completion of your clinical training.
- NCCAOM verification.** Request verification of passing the NCCAOM examinations. The exams must include the Foundations of Oriental Medicine, Acupuncture with Point Location and Biomedicine. Include verification of having taken and passed the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) clean needle technique course. The telephone number for NCCAOM in Jacksonville, Florida is 904-598-1005.

Note: If the NCCAOM examinations were not passed in English, then you need to take the Test of English as a Foreign Language (TOEFL) internet-based (IBT) exam.

- Verification of TOEFL.** You must have written verification of having passed the TOEFL IBT with at least the following scores in one sitting:
 - a. 24 on the writing section;
 - b. 26 on the speaking section;
 - c. 21 on the reading section; and
 - d. 18 on the listening comprehension section.

If you wish to be scheduled for this examination or if you want to have verification of your scores sent to this office, contact the TOEFL Registration Office at P.O. Box 6152, Princeton, NJ 08541-6151 or call 609-771-7100. The TOEFL code for Washington State is WA0201.

- Verification of licenses.** You will need to request all U.S. and foreign boards and jurisdictions where you have held a professional license to send verification. We will not accept license copies.

Information regarding the acupuncturist or acupuncture and eastern medicine program is also available on the [Acupuncturist or Acupuncture and Eastern Medicine Practitioner Program Web site](#).

You must provide proof of successful completion of didactic and clinical training courses.

A. Didactic Training—Basic Sciences and Acupuncture or Eastern Medicine Sciences

1. Completed over a minimum period of two academic years.
2. 45 quarter credits or 450 hours in the following subjects:
 - Anatomy
 - Physiology
 - Microbiology
 - Biochemistry
 - Pathology
 - Survey of Western Clinical Sciences
 - Clean Needle Technique Course
3. 75 quarter credits or 750 hours in Eastern Medicine sciences in the following subjects:
 - Fundamental Principles
 - Diagnosis
 - Pathology
 - Therapeutics
 - Meridians/vessels and points; and
 - Techniques, including electro-acupuncture

B. Clinical Training—Acupuncture or Eastern Medicine

1. Includes a minimum of 500 hours of supervised clinical training including no more than 100 hours of observation, which includes case presentation and discussion. At least 400 hours must be patient treatment.
2. Qualified instructors must observe and provide guidance to the student as appropriate. Instructors must be available to provide consultation and assistance to the student for patient treatments. Prior to initiation of each treatment, the instructors must have knowledge of and approve the diagnosis and treatment plan.
3. Patient treatment includes patient intake interview; Acupuncture or Eastern Medicine examination and diagnosis; discussion between instructor and student about the proposed diagnosis and treatment plan; applying Acupuncture or Eastern Medicine treatment principles and techniques; and charting of patient conditions, evaluative discussions and findings and concluding remarks.

Note: This form must come directly from the school where supervision took place.

Date
Stamp
Here

Revenue 0295010000

Acupuncturist or Acupuncture and Eastern Medicine Practitioner License Application

Please print clearly in ink; applications received with electronic signatures and/or initials are not accepted. 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.

Select if the following applies: 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)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> X
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Name First	Middle	Last
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Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
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Country

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

Mailing address if different from above address of record

City	State	Zip Code	County
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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. 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 health care 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 health care 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 health care 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 health care profession?
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?

3. Pre-Acupuncture or Eastern Medicine (Basic Science) Education

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. Attach an additional page if you need more space.

Full name, city and state of schools attended	Degree earned	Attendance	
		Entrance date	Ending Date

4. Acupuncture or Eastern Medicine Didactic and Clinical Program

Acupuncture or Eastern Medicine Didactic Program

Address

City	State	Zip Code	County
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Acupuncture or Eastern Medicine Clinical Program

Address

City	State	Zip Code	County
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5. Experience

In date order, list all your experience. Exclude activities listed under other sections. Attach an additional page if you need more space.

Name and location of institution	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Type of experience or specialty

6. Other License, Certification, or Registration

List all states or jurisdictions, US and foreign, where you have a health care practitioner credential. List all active, inactive and expired credentials. List the credential type and request the state and/or jurisdiction send official verification directly to this office. Attach additional pages if you need more space.

State	Profession	License Type	License		Currently Active?
			Year Issued	Number	

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 _____
(mm/dd/yyyy)

By: _____
(Signature of applicant)

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Education Completed

This form is required of all applicants prior to a license being issued. Please make copies if more space is required.

Applicant Name _____

Basic Science Courses

Year	Name of school/program	Title of course	Equivalent to this required course	Credits

Acupuncture or Eastern Medicine Education Completed

Year	Name of school/program	Title of course	Equivalent to this required course	Credits

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Acupuncturist or Acupuncture and Eastern Medicine
Practitioner Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Clinical Training Verification

Applicant's name _____

Date of Birth _____ Training dates: From _____ To _____

School or clinic name clinical training received from _____

School or clinic address _____

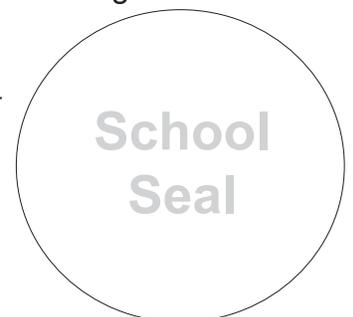
I certify that the applicant named above has met the supervised clinical training requirements of **WAC 246-803-230**, consisting of the following:

A minimum of 500 hours of supervised clinical training including no more than 100 hours of observation which includes case presentation and discussion. At least 400 hours must be patient treatment.

1. Qualified instructors must observe and provide guidance to the student as appropriate. Instructors must be qualified to provide instruction in their areas of specialization in Acupuncture or Eastern medicine as demonstrated by possession of the following:
 - a. Broad and comprehensive training in Acupuncture or Eastern medicine; and
 - b. Two years of relevant current work experience or teaching experience in Acupuncture or Eastern medicine.
2. Instructors must be available within the clinical facility to provide consultation and assistance to the student for patient treatments. Prior to initiation of each treatment, instructors must have knowledge of and approve the diagnosis and treatment plan.
3. Patient treatment includes:
 - a. Conducting a patient intake interview concerning the patient's past and present medical history.
 - b. Performing Acupuncture or Eastern medicine examination and diagnosis.
 - c. Discussion between the instructor and the student concerning the proposed diagnosis and treatment plan.
 - d. Applying Acupuncture or Eastern medicine treatment principles and techniques.
 - e. Charting of patient conditions, evaluative discussions and findings, and concluding remarks.

Approved program officer signature _____

Date _____



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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](#)

[Acupuncturist or Acupuncture and Eastern Medicine Practitioner Laws, RCW 18.06](#)

[Acupuncturist or Acupuncture and Eastern Medicine Practitioner Rules, WAC 246.803](#)

Online

[Acupuncturist or Acupuncture and Eastern Medicine Practitioner Program, Web Page](#)

[NCCAOM, http://www.nccaom.org](http://www.nccaom.org)

[TOEFL, http://www.ets.org](http://www.ets.org)