

# Pharmacy Technician Expired Credential Activation 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:

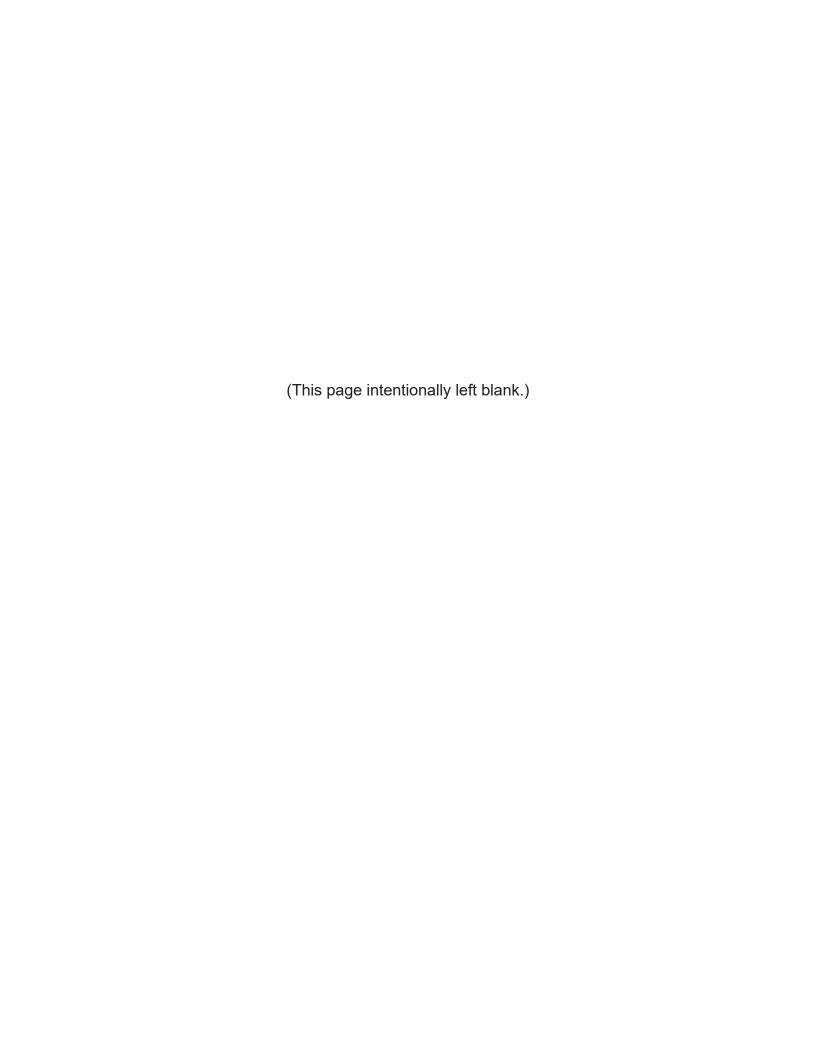
Department of Health PO Box 1099 Olympia, WA 98507-1099 Send other documents not sent with initial application to:

Pharmacy Credentialing PO 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 <a href="mailto:civil.rights@doh.">civil.rights@doh.</a> wa.gov.





# **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 Renewal Penalty Fee.
Pay Current Renewal Fee.
Pay Expired Credential 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 <a href="Declaration of No Social Security Number Form">Declaration of No Social Security Number Form</a> . 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 credential. 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. To expedite notice to the applicant, we will use the email address as the primary contact source to update the applicant on the status of their application. It is important to ensure the email address is correct and current at all times.

**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

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2. 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.
 3. Experience. List in date order your professional work experience related to the practice of pharmacy/pharmacy technician since your Washington State credential expired. Attach additional pages if you need more space.
 4. Disciplinary Action Attestation. Required by WAC 246-12-040.
 5. Continuing Education Attestation. Required by WAC 246-12-040 and in compliance with WAC 246-901-061.
 6. Applicant's Attestation. Required to be both signed and dated in order to

process the application.

in writing. You must include proof of this change. See WAC 246-12-300.

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Date Stamp Here

Revenue: 0262010000

# Pharmacy Technician Expired Credential Activation Application

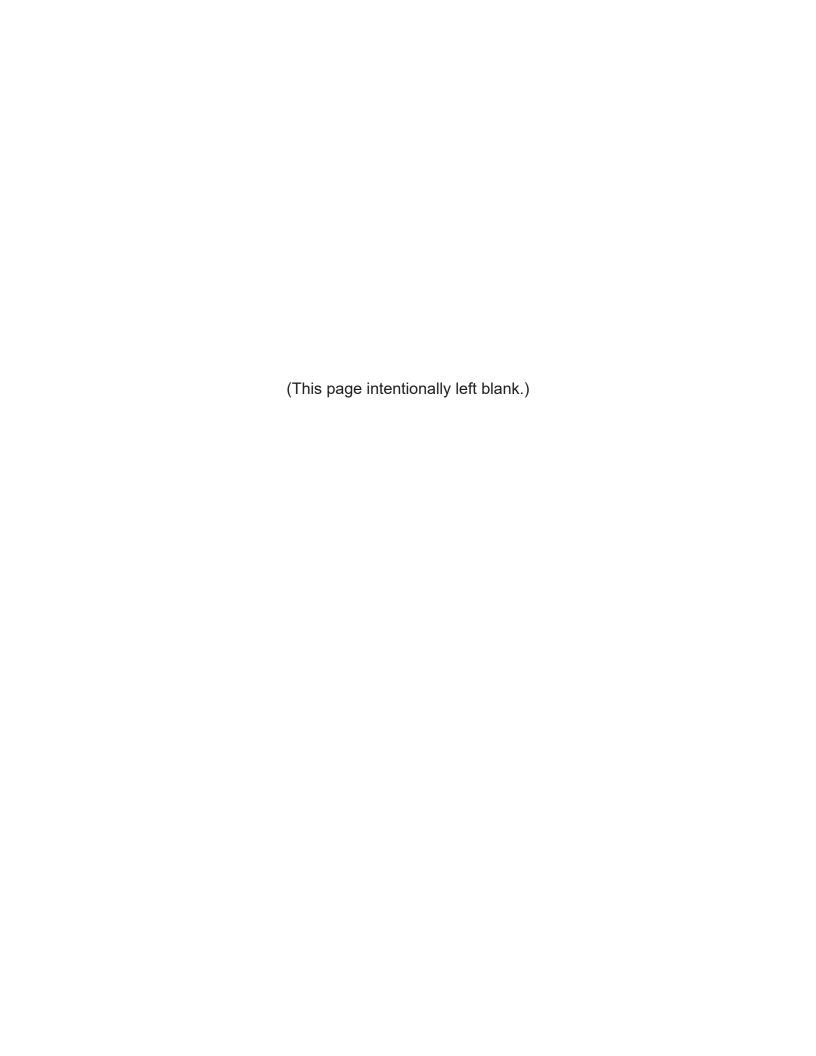
Expired Credential Activation Application							
Please print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.							
1. Demographic Inform	ation						
Social Security Number (SSN) (If you do not have a SSN, see instr		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 (ente	r 10 digit #)		Cell (enter 1	0 digit #)		
Email address							
Mailing address if different from above address of record							
City	State	Zip Code	Cou	inty			
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 ves. list name(s):							

	<del></del>	ation, or Registration  Credential					Currently In	
State/Jurisdiction	Profession	Туре	Number	Year Issued	Method of Credentialing	Force		
Statoroundation	1 1010001011	1,400	Trainibol	Tour looded	Orodonading	No	Yes	
3. Experienc	e							
	Type of experienc	e of practice and	location		start (mm/yyyy)	end (m	m/yyyy)	
4. Disciplina	rv Action Att	estation						
I certify no action har right to practice my	,	y state or tede	erai jurisdiction	or nospital, whi	cn would prevent	or restr	ict my	
I further certify I have			dential or privil	ege or have not	been restricted i	n the pra	actice	
of my profession in	lieu of or to avoid fo	rmal action.			APPLICAN	IT'S INITIALS		
5. Continuin	g Education A	Attestatio	on		<u> </u>		_	
	all continuing educa			ments for the n	ast two vears. Lai	m enclos	sina	
documentation on a	•		ctoricy require	monto for the pe	ASI IWO YEARS. I AR		_	

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6. Applicant's Attestation						
I,, declare under penalty of perjury under the laws of (Print applicant name clearly) the state of Washington the following is true and correct:						
I am the person described and identified in this application.						
I have read <u>RCW 18.130.170</u> and <u>RCW 18.130.180</u> of the Uniform Disciplinary Act.						
I have answered all questions truthfully and completely.						
<ul> <li>The documentation provided in support of my application is accurate to the best of my knowledge.</li> </ul>						
<ul> <li>I have read all laws and rules related to my profession.</li> </ul>						
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 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.						
DatedBy:(Original signature of applicant)						
(mm/dd/yyyy) (Original signature of applicant)						

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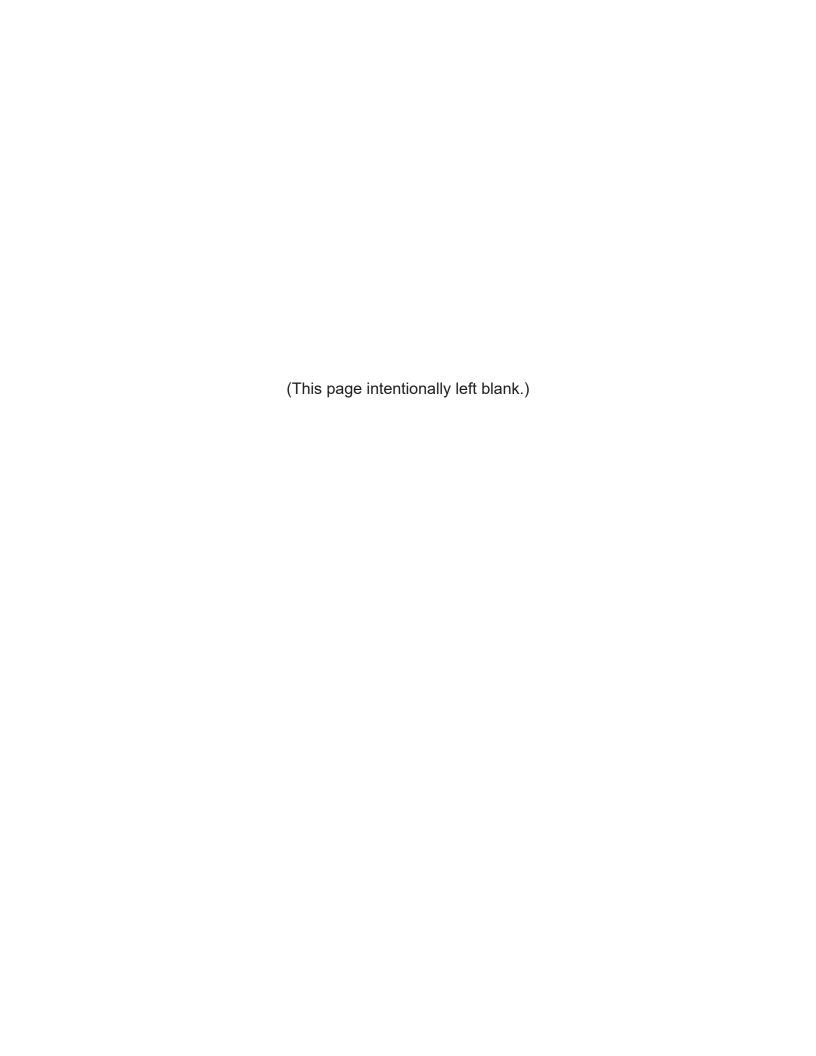




Pharmacy Quality Assurance Commission Credentialing PO Box 47877 Olympia, WA 98504-7877 360-236-4700

# **Verification of Current Active Pharmacy Practice**

			_ has been employed as a
(Print applic	cant name clearly)		
☐ Pharmacy Technician			
☐ Pharmacist			
Other, please explain _			
by this organization from _	(mm/dd/yy	yy)	(mm/dd/yyyy)
Pharmacy/Employer Info	rmation:		
Name		Phone (enter 10 digit #)	
Pharmacy State License N	umber (if applicab	le)	
Street Address			
City	State	Zip (	Code
Person Completing Form	:		
Name		Phone (enter 10 digit #) _	
Credential type and numbe	er (if applicable)		
Title			
Signature		Date	





## **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

Pharmacy Laws, RCW 18.64A

Pharmacy Rules, WAC 246-901

### **Online**

**Pharmacy Quality Assurance Commission Web site**