Washington Board of Osteopathic Medicine & Surgery

Addendum Instructions

Addendum Instructions: Complete the addendums as instructed below. Please type or print your responses. Return the completed addendums along with any and all supporting documentation to the Washington Board.

Addendum 1 – Application Questions: These questions must be completed by the applicant.

- AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by **WAC 246-12-260.** Course content can be found in **WAC 246-12-270**.

Addendum 2 – Personal Data Questions: All applications 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.

- Another jurisdiction means any other country, state, federal territory, or military authority.

Addendum 3 – Applicant's Attestation: You must sign and date this form for us to process the application. Read this very carefully.

Addendum 4 – Applicant's Attestation: Complete the top portion of the Hospital Investigative Letter and send it to each hospital in the U.S. or Canada where hospital privileges have been granted within the past five years.

- Verifications must be received directly from each hospital. This does not include postgraduate training hospitals.

- Verification for military hospital privileges may be obtained by the current duty station or, if no longer in active service, the Human Resource Command, 1 Reserve Way, St. Louis, MO 63132.

- Locum Tenens: Hospital privileges of a 30-day or longer duration.

Addendum 5 – Training Appointment Verification: (for Limited License while in postgraduate training) If you are applying for a limited license while in postgraduate training, request that the program director of your training program complete this form and return it to the address on the form.

Addendum 1
Application Questions

Please answer the following questions.

1. Application for (check one):
   - ☐ Full License _____
   - ☐ Temporary License (for full license applicants)
   - ☐ Limited License (Postgraduate Program _____

2. Application for license is made by (check one):
   - ☐ National Board Endorsement
   - ☐ FLEX Endorsement/Washington Examination
   - ☐ USMLE Endorsement/Washington Examination
   - ☐ State Examination Endorsement

3. Will documents be received in another name? ☐ Yes ☐ No
   If yes, list name(s): _____

4. Medical specialty: _____

5. Hospital Privileges: List hospitals and locations where admitting privileges have been granted within the past five years. If you need more space, attach a piece of paper.

Name of hospital and location (For locum tenens, enter only those of a 30-day or longer duration). See instructions in step 5 of the General Instructions Checklist, Hospital Privileges.	Dates attended From mm/yyyy	To mm/yyyy

6. AIDS Education and Training Attestation

   I certify that I have completed a minimum of seven (7) hours of education in the prevention, transmission, and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychological issues to include special population considerations. **AIDS training may include self study, direct patient care, online courses, or formal training.**

   Applicant's Initials _____Date_____

7. Height _____ Weight _____ Hair Color _____ Color of eyes _____

Applicant's Name _____Date _____

Addendum 2 (2 Pages)
Personal Data Questions

Please answer the following questions.
For each "yes" answer, attach a complete, signed and dated explanation.

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. ☐Yes ☐No

   "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. ☐Yes ☐No

   "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? ☐Yes ☐No

4. Are you currently engaged in the illegal use of controlled substances? ☐Yes ☐No

   "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 copy 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 documents, your application is incomplete and will not be considered.** **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.**	☐Yes ☐No
	a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction? **Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, you application is incomplete and will not be considered.**	☐Yes ☐No
	b. If you answered "yes" to question 5a, do you wish to have the decision on your application delayed until the prosecution and any appeals are complete?	☐Yes ☐No
6.	Have you ever been found in any civil, administrative or criminal proceeding to have:	☐Yes ☐No
	a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐Yes ☐No
	b. Diverted controlled substances or legend drugs?	☐Yes ☐No
	c. Violated any drug law?	☐Yes ☐No
	d. Prescribed controlled substances for yourself?	☐Yes ☐No
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.	☐Yes ☐No
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?	☐Yes ☐No
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?	☐Yes ☐No
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?	☐Yes ☐No
11.	Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐Yes ☐No
12.	Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐Yes ☐No
13.	To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐Yes ☐No
14.	Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐Yes ☐No

Addendum 3
Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of 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 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 governmental 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 _____ at _____ (city, state)

By: _____
(Signature of Applicant)

Applicant's Name _____Date _____

Board of Osteopathic Medicine and Surgery
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Addendum 4
Hospital Investigative Letter

Name of Applicant: _____ Birth Date: _____

I have applied for a license to practice osteopathic 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 directly to:

Board of Osteopathic Medicine and Surgery, P.O. Box 47877, Olympia, WA 98504-7877
360-236-4700

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 Board of Osteopathic Medicine and Surgery.

Signature of Applicant: _____Date: _____

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

   If yes, please explain _____

   _____

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

Name _____Title _____

Facility _____ Telephone Number _____

Address _____

Authorized Signature _____Date _____

Applicant's Name _____Date _____

Board of Osteopathic Medicine and Surgery
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Addendum 5
Training Appointment Verification

This is to certify that _____ has been accepted in a
(Name of osteopathic* physician)

Postgraduate training program in _____ at
(Type of residency program)

_____ for the period beginning
(WA State training institution)

_____. The individual responsible for this resident's patient care activities
(Start date)

will be _____.
(Director of program-print name)

Program Address _____

Signature _____

*A resident osteopathic physician means an individual who has graduated from an approved school of osteopathic medicine. The resident must be serving a period of postgraduate clinical training sponsored by a college or university in this state or by a hospital accredited in this state whose program is approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations. The term shall include individuals designated as intern, resident, or medical fellow.

Return Completed Form To:
Board of Osteopathic Medicine and Surgery
P.O. Box 47877
Olympia, WA 98504-7877

Applicant's Name _____Date _____