



Social Worker Associate Independent Clinical License Application Packet

Contents:

1. 670-105Contents List/SSN Information/Mailing Information..... 1 page
2. 670-106Application Instructions Checklist..... 3 pages
3. 670-107License Application..... 5 pages
4. 670-108Out-of-State Credential Verification Form 2 pages
5. 670-109Approved Supervisor Verification 1 page
6. RCW/WAC and Online Website Links..... 1 page

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:

Social Worker Associate 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.

(This page intentionally left blank.)

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 blue or black ink. It is your responsibility to submit the required forms.

Application Fee. This fee is non-refundable. You can check the online [fee page](#) for current fees. This fee may be paid by a personal check or money order, payable to the Department of Health.

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 the 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 questions. 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. Education:

List your educational preparation. Graduation with a master’s or doctoral social work educational program accredited by the Council on Social Work Education and approved by the secretary based upon nationally recognized standards.

Transcripts:

Your school must send official school transcripts directly to the Social Worker Associate Credentialing.

4. Other License, Certification, or Registration:

List all states, including Washington, where credentials are or were held.

An Out-of-State Credential Verification Form is enclosed and must be sent to each state you listed. Enter your full name and birth date at the top of the form so the state can identify you. Also, contact each state board listed for any fees they may charge you for processing the verification.

5. Declaration Working Toward Licensure:

Declare that you are working toward licensure as a Social Worker.

6. Applicant’s Attestation:

You must sign and date this for us to process the application.

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required. If your application is incomplete, you will be mailed or emailed a letter regarding the deficiencies.

- You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

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 servicemember 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.

(This page intentionally left blank.)

Date
Stamp
Here

Revenue: 0207041000

Social Worker Associate Independent Clinical License 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 |
|---|---|--|

| | | | |
|------|-------|--------|------|
| 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. 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. Education

List the graduate school(s) you attended, month, year, and major of the degree. Request your transcripts from the graduate school(s) you attended, and have the graduate school send **directly** to the Department of Health.

| Graduate School | From (mm/yyyy) | To (mm/yyyy) | Degree and Major |
|-----------------|-------------------|-----------------|------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

4. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held.

| State/ Jurisdiction | License/Certification/Registration Type | License/Certification/Registration | | Method Licensed | | |
|------------------------|---|------------------------------------|--------|-----------------|----------|---------------|
| | | Year Issued | Number | Exam | Endorse. | Grandparented |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

5. Declaration Working Toward Licensure

I declare that I am working toward licensure as a Social Worker.

| | |
|----------------------|------|
| Applicant's Initials | Date |
| | |

6. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(Name of Applicant)

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 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) (Original Signature of Applicant)

(This page intentionally left blank.)



Social Worker Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of this form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. The regulatory agency will complete page two.

| | | | | | | | | |
|---|--|--|-------|--|-------------------------|-------------|--|----------|
| Name: Last | | | First | | | Middle | | |
| Mailing Address | | | | | | | | |
| City | | | | | | State | | Zip Code |
| Phone (enter 10 digit #) | | | | | Cell (enter 10 digit #) | | | |
| Email address | | | | | | | | |
| Any other names used: | | | | | | | | |
| Type of license(s) you hold or have held in other state(s): | | | | | | | | |
| Washington State healthcare credential type you are applying for: | | | | | | | | |
| Washington State healthcare credential number (if available): | | | | | | Date Issued | | |

Have the licensing agency complete page two and return this form to the address listed above.
If you have any questions, please call 360-236-4700.

This form may be duplicated.

(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 license, certification, or registration holder: | | |
| Authority providing verification: (state, name, and title) | | |
| Applicant was credentialed by: <input type="checkbox"/> Written Examination | Date: | Score: |
| Name of examination: | | |
| <input type="checkbox"/> Other Examination | Date: | Score: |
| Name of examination: | | |
| Is credential current: <input type="checkbox"/> Yes <input type="checkbox"/> No | Expiration Date: | |
| Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," please attach explanation. | | |
| Has this credential ever been denied? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Suspended? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Revoked? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Surrendered? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Reinstated? | <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

(SEAL)

Signature: _____

Title: _____

Date: _____



Social Worker Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Approved Supervisor Verification

To the Supervisor:

Please review [WAC 246-809-334](#). To supervise a licensed social worker advanced associate or social worker independent clinical associate, you must hold a license without restrictions that has been in good standing for at least two years.

You must not be a blood or legal relative or cohabitant of the licensed associate, licensed associate’s peer, or someone who has acted as the licensed associate’s therapist within the past two years.

Prior to the commencement of any supervision you must provide the licensed associate a declaration, stating that you have met the requirements of [WAC 246-809-334](#) and you qualify as an approved supervisor.

As an approved supervisor, I attest I have completed the following:

- **A minimum of fifteen clock hours of training in clinical supervision obtained through:**
 - Supervision course; or
 - Continuing education credits on supervision; or
 - Supervision of supervision; or
 - Or any combination of these; and
- **Twenty-five hours of experience in supervision of clinical practice; or**

I attest I will gain thorough knowledge of the supervisee’s practice activities including:

- Practice setting
- Record keeping
- Financial management
- Ethics of clinical practice
- A backup plan for coverage

Declaration of Supervision—must be completed by supervisor and provided to licensed associate prior to the commencement of supervision in accordance with [WAC 246-809-334](#).

I, _____, a licensed _____ in the State of _____
(Name of Supervisor)
 _____ with license # _____

attests to _____ that I have read and met all the requirements in connection
(Name of Licensed Associate)
 with [WAC 246-809-334](#).

Signature of Supervisor _____ Date _____

(This page intentionally left blank.)



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](#)

[Licensed Social Worker Laws, RCW 18.225](#)

[Licensed Social Worker Rules, WAC 246-809](#)

[Standards of Professional Conduct, WAC 246-16](#)

Online

[Social Worker Program, Web Page](#)

Get important information about your credential type by [subscribing to email alerts](#).