Washington State Department of HEALTH

Naturopathic Physician Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Intravenous Therapy Attestation Authorization

I attest and affirm that I have (choose one):

☐ Completed sixteen hours of training during the course of naturopathic medicine instruction at the board approved naturopathic medical school listed below.

Please indicate the naturopathic medical school, and year of graduation. Please print clearly.

Name of School _____

Year Graduated _____

☐ Completed sixteen hours of an extended/continuing education course, of which at least eight hours were graduate level training, sponsored by a school approved under chapter **18.36a, 18.71, 18.57, or 18.79 RCW**.

List the Name and address of institution. Please print clearly. Must be a school approved under chapter **18.36a**, **18.71**, **18.57**, or **18.79 RCW**.

_____

_____

The instruction sponsored by the school listed above that was titled _____ and completed on _____, included indications, contraindications,formularies, emergency protocols, osmolarity calculation, aseptic technique, and proper documentation.

I further affirm, in accordance with **WAC 246-836-220**, I will retain training documentation for at least five years from the date of this attestation. I understand failure to give this documentation upon request may result in disciplinary action against my license.

Print Practitioner's name: _____

Practitioner's signature: _____ Date: _____

License Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____

For Office Use Only:

☐ Approved ☐ Disapproved: _____ Review Date: _____

Signature: _____