Reflexologist Certification Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360-236-4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

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:

Reflexologist Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Washington State Department of Health

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 typed or printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

☐ **Application Fee**. This fee is **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. Please call the Customer Service Center at 360-236-4700 if you do not have one.

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.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your certification. 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.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification or Registration:**
List all states where credentials are or were held. Attach additional pages if you need more space.

☐ **4. Education and Training:**
List in date order your educational preparation and training. Attach additional pages if you need more space.

☐ **5. Experience:**
List in date order all professional experience and practice from date of graduation from professional college. Attach additional pages if you need more space.

☐ **6. Attestation of Waiver of Examination:**
Complete this section only if you are applying to obtain a waiver of the examination for certification.

☐ **7. Examination Information:**
If you have taken and passed the American Reflexology Certification Board (ARCB) reflexologist certification exam, you must have a written verification from the examination company sent directly to the Department of Health.

☐ **8. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training required. A minimum of four hours is required. Course content can be found in **WAC 246-12-270**.

☐ **9. Applicant's Attestation:**
You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

Washington State Department of Health

Certification Requirements

Thank you for applying to become a reflexologist in Washington State. In order to qualify for certification you must complete the following.

☐ Complete and submit the application, with an original signature, date, and **fee**.

☐ You must be 18 years of age or older as required under **WAC 246-831-010**.

☐ **Education and Training:**
Successful completion of:

- A course of study in an approved reflexology school, program, or apprenticeship program which has a minimum of 200 hours of instruction and includes the skills identified in **WAC 246-831-040**.

  Reflexology Program School Completion Form: Have your reflexology school, program, or apprenticeship program mail your school completion form with the date of completion listed.

☐ **Experience:**
List in date order your professional experience and practice from date of completion from your reflexology program. Include the month, day, and year. Attach additional pages if you need more space.

☐ **Examination:**
Successful completion of:

- The American Reflexology Certification Board (ARCB) written examination.
- The Washington State Reflexology Jurisprudence Examination.

Note: It is the applicants responsibility to ensure that an official verification of the applicants successful completion of the examination is submitted to the Department of Health.

☐ Four hours of AIDS education and training as required under **WAC 246-831-010**

☐ Out-of-State credential Verification must be received from every state where you hold or have held a healthcare practitioner credential.

Note: Many states charge a verification processing fee. Contact them prior to request to prevent delays in processing.

Waiver of Examination:

To apply for a waiver of the examination for certification as a reflexologist you must complete the following:

- ☐ Your application must be received between July 1, 2013 and July 1, 2014.
- ☐ Complete and submit the application, with an original signature, date, and **fee**.
- ☐ Four hours of AIDS education and training as required under **WAC 246-831-010**
- ☐ Completion of the Washington State Reflexology Jurisprudence Examination.
- ☐ Verification that you have practiced reflexology as a licensed massage practitioner for at least five years prior to July 1, 2013;

  OR

  Proof of successful completion of a course in a reflexology program;

  OR

  Verification that you hold a current reflexology credential in another state or a territory of the United States which has substantially equivalent standards to those of Washington State.

Other Information:

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.
- The initial certification will expire on your birthday unless the license is issued within 90 days of your birthday. See **WAC 246-12-020(3)**.
- Certifications must be renewed every year on your birthday as provided in **WAC 246-12(2)**. A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding the reflexology program is available on our **Web site**.

Note: You cannot practice reflexology until your certification is issued.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0242110001

Reflexologist Certification Application

Please type or 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 Information

Social Security Number (If you do not have a social security number, see instructions.)

☐ Male
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City | State | Country

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)

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 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):

For Office Use Only

Certification # _____ Issue date _____

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.

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

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, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

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? ..... ☐ ☐

3. 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.

State	Credential type	Credential				
		Year Issued	Number	Temporary	Exam	Currently Active?

4. Education and Training

List in date order, most recent to later, your educational preparation and training. Attach additional pages if you need more space.

Schools Attended Full Name, City and State	Degree Earned	Attendance	
		From (mm/dd/yyyy)	To (mm/dd/yyyy)

5. Experience

List in date order, most recent to later, your professional experience and practice from date of completion from your reflexology program. Attach additional pages if you need more space.

Type of experience and location	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

6. Attestation of Waiver of Examination (please check one)

☐ I certify that I have practiced reflexology as a licensed massage practitioner for at least five years prior to July 1, 2013.
Or

☐ I have provided proof of completion in a course of study in a reflexology program approved by the secretary.
Or

☐ I certify that I currently hold a reflexology credential in another state or territory of the United States which has substantially equivalent education and training. I have submitted an **Out-of-State Credential Verification form** as proof of certification.

Applicant's Initials	Date

7. Examination Information

Have you taken and passed the American Reflexology Certification Board written examination?

☐ Yes ☐ No

State examination taken in:_____ Date (mm/dd/yyyy): _____

Note: Official verification in the form of scores or certificates must be sent directly from the American Reflexology Certification Board to the Department of Health.

8. AIDS Education and Training Attestation

I certify I have completed the minimum of four 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 psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

9. 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 **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 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 _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Washington State Department of Health
Reflexologist Credentialing
PO 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 & title)		
Type of healthcare license, certification or registration:		
Healthcare license, certification or registration number:		
Applicant was credentialed by: ☐ Written Examination	Date:	Score:
☐ Other Examination	Date:	Score:
Name of examination:		
☐ Endorsement		
☐ Not applicable (please explain):		
Is credential current: ☐ Yes ☐ No Expiration Date: Original Issuance Date:		
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no," please attach explanation.		
Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ 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? ☐ Yes ☐ No		

(SEAL)

Signature: _____

Title: _____

Date: _____

Washington State Department of Health
Reflexology Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Reflexology Program School Completion form

Please use blue ink to complete this form

If your school offers more than one reflexology program or if there is more than one campus, each individual campus and/or program must be approved by the secretary. The school program or campus must be approved before the applicant's graduation date. If an applicant did not complete the program from a Secretary approved campus or program, they are not eligible for certification.

Candidate name _____Check if candidate completed transfer program ☐

Approved Reflexology Program

Name of school _____

Name of approved program _____
Some schools offer more than one program. Approved program name is required.

Entry date of program _____ /_____ / _____

Date program completed _____ / _____ / _____

Number of hours completed _____

The student must complete the school hours approved by the Secretary.

Note: To be certified with the state of Washington, applicants must meet the training requirements as outlined in WAC 246-831-040 titled educational requirements, which states "training in reflexology must include a minimum of 200 hours of instruction.

School registrar or representative authorized signature _____

Date training completed _____

Note: Only program completion forms sent directly from the school to the Washington State Department of Health will be accepted.

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Washington State Department of Health

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act, UDA RCW 18.130

Administrative Procedure Act, APA RCW 34.05

Administrative procedures and requirements, WAC 246-12

Reflexology Laws, RCW 18.108

Reflexology Rules, WAC 246-831

On-Line

Reflexology Program, Web Page

American Reflexology Certification Board, www.arcb.net

AIDS Training Resources, Reference Page