



Western Washington Area Health Education Center
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Volunteer Retired Providers PROGRAM

Volunteer Healthcare Provider Certification

To authorize license renewal payment as a participant in the Volunteer Retired Providers License Program **please return this signed certification with your license renewal form and request for license payment to:**

Volunteer Retired Providers License Program
Department of Health
Office of Community and Rural Health
P.O. Box 47834
Olympia, Washington 98504-7834

I, (Please print) _____, certify that during the time that this license is in effect:

1. I will not receive remuneration for the practice of primary health care, either as an independent practitioner or as an employee; and
2. I will be providing volunteer services at a clinic which is a participant in the Volunteer Retired Provider Program; and
3. I will provide care to low income patients, regardless of their ability to pay; and
4. My health care services are limited to non-invasive care services. Noninvasive medical care is defined by the legislation authorizing this program to include injections, suturing of minor lacerations and incisions of boils or superficial abscesses. Noninvasive dental care is defined by the legislation authorizing this program to include diagnosis, oral hygiene, restoration and extractions.
5. I certify that I have completed all continuing education required for my license renewal.
6. My professional license number is: _____

Signature

_____/_____/_____
Date