

# APPLICATION CHECKLIST

*(DDDS Specialized Medical Consultative Services)*

Complete and return this form as part of your application packet.

APPLICANT	DDDS USE ONLY
<b>Applicant Name:</b> (please print)	<b>Evaluator's Name:</b> (please print)
<input type="checkbox"/> Contractor Intake	<input type="checkbox"/> Contractor Intake
<input type="checkbox"/> Copy of Business License	<input type="checkbox"/> Copy of Business License
<input type="checkbox"/> Applicant Certification and Assurances	<input type="checkbox"/> Applicant Certification and Assurances
<input type="checkbox"/> Acknowledgement of Professional Qualifications	<input type="checkbox"/> Acknowledgement of Professional Qualifications
<input type="checkbox"/> Statement of Agreement	<input type="checkbox"/> Statement of Agreement
<input type="checkbox"/> Copy of Washington State Medical License	<input type="checkbox"/> Copy of Washington State Medical License
<input type="checkbox"/> Curriculum Vitae or Resume	<input type="checkbox"/> Curriculum Vitae or Resume

**To Register for Payment, follow the online instructions at:**  
<https://ofm.wa.gov/sites/default/files/public/itsystems/payee/VendorRegistration.pdf>