DEFICIENCY LETTER LOG SHEET

ITEM	Calendar Date	Julian Date
Application Received	OCT 0 2 1998	
Deficiency Letter 1	OCT 0 6 1998	
Deficiency Letter 2	DEC 1 5 1998	
Deficiency Letter 3	JAN 2 2 1999	
Deficiency Letter 4		
Deficiency Letter 5		
Deficiency Letter 6		
Deficiency Letter 7		
Deficiency Letter 8		
Deficiency Letter 9		
Deficiency Letter 10		
Deficiency Letter 11		
Deficiency Letter 12		
Deficiency Letter 13		
Deficiency Letter 14		
Deficiency Letter 15		
Deficiency Letter [illegible]		
Deficiency Letter [illegible]		
Deficiency Letter 18		
Deficiency Letter 19		
Deficiency Letter 20		

DATE	TELEPHONE LOG	INITIALS

Physician Application Worksheet

License Number

Name: Edwards Louis Date of Birth 3-24-42

Date Received 10-2-98 Date Completed Signature

325 Fee ☑ Photo ☑ Personal Data ☑ AIDS ☑ Affidavit ☐ Archive File

Chronology ☒ Complete

Missing: 6/70 to 10/70; 6/72 to 11/75; to

☐ Temporary Permit Requested Status

FSMB	AMA	ECFMG	Reinstatement
10/8	10/29		

Personal Data Questions	Documentation Received
9	

Malpractice Cases	Synopsis	Original Complaint	Disposition
1	✓	✓	✓
2			
3			
4			

Medical School

Name U. Texas Year of Degree 69

☒ U.S. ☐ Canadian ☐ International

2/1 Transcripts ☐ Translations

Examination Type ☒ National Boards ☐ FLEX ☐ USMLE ☐ State Exam ☐ LMCC 10/12 Scores Received

Received	Post Graduate Training Programs	Accreditation Verified
11/9	Baylor 7/69-6/70	
11-20	" " 10/70-6/72	
11-20	11/75-2/77	

Received	Post Graduate Training Programs	Accreditation Verified
	✓ No month	

Received	State Licensure
10/5	Tx
10/5	UT

Received	Hospital Privileges
10/12	Women's
10/8	Harris Co.

Approved Signature Date

Comments:

see attached for Commission Member approval.

Return with check or money order to ensure proper credit of your license application fee.

DEPOSIT CREDIT

Physician & Surgeon

Edwards Jerry

NAME (Please Print)

DATE

DOH 657-079 (4/94)

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Washington State Department of Health

☐ Check ☐ Money Order

$ 325.00

Please note amount enclosed, and return with your application.

1A 0252090000 00237

001622 10/02/95 32500

MEDICAL QUALITY ASSURANCE COMMISSION

FEB 25 1999

COMMISSION MEMBER APPLICATION REVIEW SLIP DEPT OF HEALTH

APPLICANT NAME: Edwards, Louis MD 99-02-007 **DATE REVIEWED** 2-10-99

TO: Jan Paxton, PA-C

REVIEWER: Susan Anthony

COMMENTS: MD applicant with 2 dismissed malpractice cases and 1 closed complaint through TX (closed for lack of sufficient evidence). Please review.

REVIEWING COMMISSION MEMBER COMMENTS: Cases were either dismissed or closed so there is no reason to deny —

APPROVED: X **DISAPPROVED:** **DATE:** 2-22-99

SIGNATURE: Janice M. Paxton PA-C

RETURN REVIEW BY:

LICENSING MANAGER:

PROGRAM REPRESENTATIVE:

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099
(360) 753-2844
(360) 664-3909

RECEIVED
DEC 18 1998
HPQA

FOR OFFICE USE ONLY	
ISSUANCE DATE	
LICENSE #	37067

LICENSE #

APPLICATION FOR LICENSE TO PRACTICE MEDICINE
APPLICABLE FOR MD'S ONLY

☑ National Boards ☐ Other State Exam ☐ LMCC (must have been obtained after 1969)
☐ FLEX Examination ☐ USMLE Examination

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL
Edwards	Louis	Jerry

ADDRESS: 5606 ST PAUL

CITY	STATE	ZIP	COUNTY
Bellaire	TX	77401	HARRIS

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-919-030, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	SOCIAL SECURITY NUMBER
(713) 664 9833	1 - DOH Licensee Social Security Number - RCW 42.56.350...

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
☐ Female ☑ Male	03/24/42	Dallas, Texas

Have you previously applied for a Washington State license or limited license? ☐ Yes ☑ No

Have you ever been known under any other name(s)? ☑ Yes ☐ No

If yes, list name(s): Jerry Edwards, L. Jerry Edwards

HEIGHT	WEIGHT
6'	175 lb

EYE COLOR	HAIR COLOR
Brown	Black

MEDICAL SCHOOL	YEAR OF GRADUATION
U. of Texas Southwestern	1969

MEDICAL SPECIALITY: Obstetrics and Gynecology

DOH 657-020 (REV 10/97)

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 explain.	☐	☑

"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, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☑

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☑
4. Are you currently engaged in the illegal use of controlled substances?	☐	☑

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☑
b. a charge of a sex offense?	☐	☑
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☑
6. Have you ever been found in any civil, administrative or criminal proceedings 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, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☑
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☑
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☑
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", explain 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, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☑
9. 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?	☑	☑

2. PERSONAL DATA QUESTIONS (continued)

	YES	NO
10. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☑
11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☑
12. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☑
13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☑

3. EDUCATION AND EXPERIENCE

Provide a chronological listing of your educational preparation and post-graduate training.
(Attach additional 8 1/2 X 11 sheets if necessary.)

Schools Attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Number of Years Attended	Dates Attended From (mo/yr)	Dates Attended To (Mo/Yr)	Diploma or Degree Obtained (Quote titles in original language and translate to English.)
Medical Education (List all Medical Schools Attended)				
U. of Texas Southwestern	4	Sept 65	Jun 69	Medical Doctor
Post-Graduate Training (List all Programs Attended)				
Baylor Affiliated Pediatrics	1	7/69	6/70	
Baylor Aff. OB/GYN	4	10/70 10/73	6/72 2/77	

4. PROFESSIONAL EXPERIENCE

In chronological order list all professional experience received since graduation from medical school to the present.
(Exclude activities listed under other sections, identify any periods of time break of 30 days or more.)
(Attach additional 8 1/2 X 11 sheets if necessary.)

Nature of Experience or Practice	Dates of Experience From (mo/yr)	Dates of Experience To (Mo/Yr)
General OB/GYN Practice	2/77	6/92
Medical Director, Planned Parenthood of Houston	9/91	6/98
Clinical Faculty, Baylor College of Medicine	2/77	Present

5. HOSPITAL PRIVILEGES

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. (Attach additional 8 1/2 X 11 sheets if necessary.)

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	DATES Beginning (mo/yr)	DATES Ending (mo/yr)
The Womans Hospital, 7600 Fannin, Houston, TX 77054	11/82	7/98
Harris County Hospital Dist, Ben Taub Hospital	2/77	Present

6. LICENSES IN OTHER STATES

List all licenses to practice medicine in any state, Canadian province or other country. (Include whether active or inactive.)

State, County or Province	Date License Issued	License Number	Basis of Licensure: Examination (Date Passed)	Basis of Licensure: Endorsement	Status of License Active or Inactive	Any Limitations on License
Texas	6/69	D5977	6/69		Active	NO
UTAH	6/94	94-272536		✓	Active	NO

7. FIFTH PATHWAY (Foreign Trained Applicants only) (Attach additional 8 1/2 X 11 sheets if necessary.)

Name and Location of Fifth Pathway Program	Name and Location of Hospital	Dates Attended: Beginning (mo/yr)	Dates Attended: Ending (mo/yr)

8. AIDS AFFIDAVIT

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS. I understand I must maintain records documenting said education, for two (2) years and be prepared to submit those records to the Department of Health if requested. (WAC 246-919-380)

Louis Jerry Edwards — APPLICANT'S SIGNATURE — 10-12-98 — DATE

9. APPLICANT'S ATTESTATION

I, Louis Jerry Edwards, certify that I am the person described and identified in this application, that I have read 18.130.170 RCW and 18.130.180 RCW, of the Uniform Disciplinary Act, and that I have answered all questions in the application truthfully and completely and the documentation provided in support of the application is, to the best of my knowledge, accurate. I understand that the Department may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Commission any information, files or records required by the Commission for its evaluation of my professional, ethical and physical qualifications for licensure in the State of Washington. I understand the Commission may request a physical and mental evaluation to determine my fitness for practice.

Louis Jerry Edwards — APPLICANT'S SIGNATURE — 10-12-98 — DATE

Official Use Only

Washington State Records Center

: Division

RECEIVED
OCT 02 1998
HPS

FOR OFFICE USE ONLY	LICENSE #
ISSUANCE DATE	
LICENSE #	

ON FOR LICENSE TO PRACTICE MEDICINE
APPLICABLE FOR MD'S ONLY

her State Exam ☐ LMCC (must have been obtained after 1969)
MLE Examination

llow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL
Edwards	Louis	Jerry

ADDRESS: P.O. Box 981892 ; 2305 Red Pine Road

CITY	STATE	ZIP	COUNTY
Park City	UT	84098	Summit

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-919-030, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	SOCIAL SECURITY NUMBER
(435) 645-9113	1 - DOH Licensee Social Security Number - RCW 42....

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
☐ Female ☑ Male	03/24/42	Dallas, Texas

Have you previously applied for a Washington State license or limited license? ☐ Yes ☑ No

Have you ever been known under any other name(s)? ☑ Yes ☐ No

If yes, list name(s): Jerry Edwards

HEIGHT	WEIGHT
6'	175 lb

EYE COLOR	HAIR COLOR
Brown	Black

MEDICAL SCHOOL	YEAR OF GRADUATION
U. of Texas Southwestern	1969

MEDICAL SPECIALITY: Obstetrics and Gynecology

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no

DOH 657-020 (REV 10/97)

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	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 explain.	☐	☑
"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, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.		
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3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☑
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5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☑
b. a charge of a sex offense?	☐	☑
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☑
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a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☑
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☑
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☑
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", explain 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, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☑
9. 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?	☐	☑

2. PERSONAL DATA QUESTIONS (continued)

	YES	NO
10. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☑
11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☑
12. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☑
13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☑

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Medical Education (List all Medical Schools Attended)				
U. of Texas Southwestern,	4	Sept 65	6169	Medical Doctor
Post-Graduate Training (List all Programs Attended)				
Baylor Affiliated Hospitals, Houston Straight Pediatrics Internship	1	7/69	6/70	
Baylor Affiliated Hospitals, Houston, TX OB/GYN Residency	4	10-70 → 11-75	6/72 → 2-77	

4. PROFESSIONAL EXPERIENCE

In chronological order list all professional experience received since graduation from medical school to the present.
(Exclude activities listed under other sections, identify any periods of time break of 30 days or more.)
(Attach additional 8 1/2 X 11 sheets if necessary.)

Nature of Experience or Practice	Dates of Experience From (mo/yr)	Dates of Experience To (Mo/Yr)
General OB/GYN, Private Practice, Houston TX	2/77	6/92
Medical Director, Planned Parenthood of Houston	9/91	6/98
Clinical Faculty/Dept OB/GYN Baylor College of Medicine	2/77	Present

5. HOSPITAL PRIVILEGES

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. (Attach additional 8 1/2 X 11 sheets if necessary.)

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	DATES Beginning (mo/yr)	DATES Ending (mo/yr)
The Woman's Hospital of Texas, 7600 Fannin Houston TX 77054	11/81	7/98
Harris County Hospital District, Ben Taub Hospital	2/77	Present

6. LICENSES IN OTHER STATES

List all licenses to practice medicine in any state, Canadian province or other country. (Include whether active or inactive.)

State, County or Province	Date License Issued	License Number	Basis of Licensure: Examination (Date Passed)	Basis of Licensure: Endorsement	Status of License: Active or Inactive	Any Limitations on License
Texas	1969	D5977	NBME 1969		Active	NO
UTAH	1994	94-272536	NBME 1969	✓	ACTIVE	NO

7. FIFTH PATHWAY (Foreign Trained Applicants only) (Attach additional 8 1/2 X 11 sheets if necessary.)

Name and Location of Fifth Pathway Program	Name and Location of Hospital	Dates Attended: Beginning (mo/yr)	Dates Attended: Ending (mo/yr)

8. AIDS AFFIDAVIT

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS. I understand I must maintain records documenting said education, for two (2) years and be prepared to submit those records to the Department of Health if requested. (WAC 246-919-380)

Louis Jerry Edwards — APPLICANT'S SIGNATURE

9/27/98 — DATE

9. APPLICANT'S ATTESTATION

I, Louis Jerry Edwards, certify that I am the person described and identified in this application, that I have read 18.130.170 RCW and 18.130.180 RCW, of the Uniform Disciplinary Act, and that I have answered all questions in the application truthfully and completely and the documentation provided in support of the application is, to the best of my knowledge, accurate. I understand that the Department may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Commission any information, files or records required by the Commission for its evaluation of my professional, ethical and physical qualifications for licensure in the State of Washington. I understand the Commission may request a physical and mental evaluation to determine my fitness for practice.

Louis Jerry Edwards — APPLICANT'S SIGNATURE

DATE

Official Use Only

Washington State Records Center

Jerry Edwards, M.D.
5606 St Paul
Bellaire, Tx 77401-2615
(713)669-6933 Fax (713)669-9894
E-mail je@mail.com

Betty Elliott
Program Representative
State of Washington, Department of Health
1300 SE Qyuince St
P.O. Box 47866
Olympia, Wa 98504-7866

Dear Ms Elliott,

Thank you for your letter of December 15. I have enclosed the requested Medical School Transcript.

To complete the missing chronology:

When I finished my Straight Pediatric Internship in June 1970 I was not sure what residency program I wanted to apply for. I therefore requested and was allowed to continue in an intern status and rotate through the departments that interested me. After completing 3 months I applied for and was accepted for a residency in the Baylor Ob/Gyn program.

The period from 6/72 to 11/75 I was in the U.S. Army (see enclosed discharge orders.) I practiced as a general medical officer in Nuremberg Germany during this time.

My postgraduate training was as follows:
Straight Pediatric Intern Baylor Affiliated Hospitals July 1969-June 1970
Rotating intern Baylor Affiliated Hospitals July 1970-October 1970
Resident Obstetrics and Gynecology Baylor Affiliated Hospitals November 1970 to June 1972.
Military July 1972-October 1975. Honorable Discharge, Rank Major USAR
Resident in Obstetrics and Gynecology November 1975-January 1977

Please let me know if you need any additional information or documentation. Please note the corrected address since I no longer receive mail at my Utah address.

Sincerely,

Jerry Edwards, M.D.

Enc: Transcript, discharge orders

THIS IS AN IMPORTANT RECORD
SAFEGUARD IT.

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. SEX	3. SOCIAL SECURITY NUMBER	4. DATE OF BIRTH	YEAR	MONTH	DAY
EDWARDS LOUIS JERRY	M	1 - DOH Licensee Social Securi...		42	03	24

5. DEPARTMENT, COMPONENT AND BRANCH OR CLASS	6a. GRADE, RATE OR RANK	6b. PAY GRADE	7. DATE OF RANK	YEAR	MONTH	DAY
ARMY USAR MEDICAL CORPS	MAJOR	04		73	05	30

8a. SELECTIVE SERVICE NUMBER	8b. SELECTIVE SERVICE LOCAL BOARD NUMBER, CITY, STATE AND ZIP CODE	8c. HOME OF RECORD AT TIME OF ENTRY INTO ACTIVE SERVICE (Street, RFD, City, State and ZIP Code)
NONE	NONE	5320 VALERIE BELLAIRE TEXAS 77401

9a. TYPE OF SEPARATION	9b. STATION OR INSTALLATION AT WHICH EFFECTED
RELIEF FROM ACTIVE DUTY	FORT JACKSON SOUTH CAROLINA 29207

9c. AUTHORITY AND REASON	9d. EFFECTIVE DATE	YEAR	MONTH	DAY
----------		75	10	16

9e. CHARACTER OF SERVICE	9f. TYPE OF CERTIFICATE ISSUED	10. REENLISTMENT CODE
HONORABLE	NONE	----------

11. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	12. COMMAND TO WHICH TRANSFERRED
130TH GEN HOSP (E1-WBKEAAA) USAREUR	USAR CON GP (REINF) RCPAC 9700 PAGE BLVD ST LOUIS MO 63132

13. TERMINAL DATE OF RESERVE/MSE OBLIGATION	YEAR	MONTH	DAY
	78	01	27

14. PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE (City, State and ZIP Code): BELLAIRE TEXAS

15. DATE ENTERED ACTIVE DUTY THIS PERIOD	YEAR	MONTH	DAY
	72	07	10

16a. PRIMARY SPECIALTY NUMBER AND TITLE	16b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER
D3108 OBSTETRICIAN AND GYNECOLOGIST	070.108 OBSTETRICIAN AND GYNECOLOGIST

17a. SECONDARY SPECIALTY NUMBER AND TITLE	17b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER
NONE	NONE

18. RECORD OF SERVICE	YEARS	MONTHS	DAYS
(a) NET ACTIVE SERVICE THIS PERIOD	03	03	07
(b) PRIOR ACTIVE SERVICE	00	00	00
(c) TOTAL ACTIVE SERVICE (a + b)	03	03	07
(d) PRIOR INACTIVE SERVICE	05	04	20
(e) TOTAL SERVICE FOR PAY (c + d)	08	07	27
(f) FOREIGN AND/OR SEA SERVICE THIS PERIOD	03	01	24

19. INDOCHINA OR KOREA SERVICE SINCE AUGUST 5, 1964: ☐ YES XX NO

20. HIGHEST EDUCATION LEVEL SUCCESSFULLY COMPLETED (In Years): SECONDARY/HIGH SCHOOL 12 YRS (1 - 12 grades) COLLEGE 11 YRS

21. TIME LOST (Preceding Two Yrs)	22. DAYS ACCRUED LEAVE PAID	23. SERVICEMEN'S GROUP LIFE INSURANCE COVERAGE	24. DISABILITY SEVERANCE PAY	25. PERSONNEL SECURITY INVESTIGATION	
				a. TYPE	b. DATE COMPLETED
NONE	22	☐ $15,000 ☐ $5,000 XX$20,000 ☐ $10,000 ☐ NONE	☐ NO ☐ YES NONE AMOUNT	NONE	NONE

26. DECORATIONS, MEDALS, BADGES, COMMENDATIONS, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED

NATIONAL DEFENSE SERVICE MEDAL

27. REMARKS

PERM MAJ USAR APTD 751017
COUNTRY OF LAST OVERSEAS SERVICE: GERMANY
TOTAL TIME LOST: NONE

28. MAILING ADDRESS AFTER SEPARATION (Street, RFD, City, County, State and ZIP Code)	29. SIGNATURE OF PERSON BEING SEPARATED
4901 WELFORD BELLAIRE TEXAS 77401	Louis J Edwards
30. TYPED NAME, GRADE AND TITLE OF AUTHORIZING OFFICER	**31. SIGNATURE OF OFFICER AUTHORIZED TO SIGN**
ELAYNE H. GROSSO 2LT AGC ASST ADJUTANT	Elayne H Grosso

DD FORM 1 NOV 72 214 — PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE. — THIS IS AN IMPORTANT RECORD SAFEGUARD IT — REPORT OF SEPARATION FROM ACTIVE DUTY

1

THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL SCHOOL

STUDENT'S PERMANENT RECORD -- DALLAS, TEXAS

Name Mrs. Mr. Miss: Edwards, Louis Jerry

M.D. Degree Received June 2, 1969

Internship: Ben Taub Children's Hosp., Houston, Texas

Dallas Address: 3930 Holland

Date of Birth: March 24, 1942

Parent's Full Name: Louis G. Edwards

Parent's Address: Box 1101 Kermit, Texas

Preparatory School: Kermit HS, Kermit

Last College Attended: U of Texas; Rice University

Military Status: Veteran? No Air Force..... Army..... Navy.....

Place of Birth: Dallas, Texas

Church Affiliation: Baptist

Married? No; yes

Date of graduation: 1960

Degree: B.A. Year 1964

First Year Date: 9-13-65 / 6-4-66			Second Year Date: 9-12-66/6/3/67			Third Year Date: 9-11-67/6-1-68			Fourth Year Date: 9/9/68-5/31/69		
COURSE	GRADE	CREDIT	COURSE	GRADE	CREDIT	COURSE	GRADE	CREDIT	COURSE	GRADE	CREDIT
GROSS ANATOMY	81	3	INTROD. TO MEDICINE	92	2	MEDICINE	81	8	OBSTETRICS-GYNECOLOGY	85	2
MICROANATOMY	88	2	MICROBIOLOGY	82	2.	OBSTETRICS-GYNECOLOGY	87	2	PEDIATRICS	92	2
NEURO-ANATOMY & PHYSIOLOGY	86	1.5	PATHOLOGY (GENERAL))	86	4	PEDIATRICS	84	2	PSYCHIATRY	91	2
BIOCHEMISTRY	86	2	CLINICAL PATHOLOGY)			SURGERY	90	1.5	SURGERY.	80	5
BIOPHYSICS	90	0.5	PHARMACOLOGY	86	2						
PHYSIOLOGY	85	3	PREVENTIVE MED & PUB. HEALTH	88	0.5						
PSYCHIATRY	86	0.5	PSYCHIATRY	83	0.5						

I HEREBY CERTIFY THAT THIS IS A TRUE COPY OF THE ORIGINAL DOCUMENT.

OFFICIAL SEAL
NADIA KUSHCH
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 3-25-97

3-25-94 Nadia Kushch

Gen Av.: 85 Rank In Class: Up.3d/101

Gen Av.: 86 Rank In Class: Mid.3d/98

Gen Av.: 83 Rank In Class: #56/100

Gen Av.: 85 Rank in Class: #67/96

11-65 500

3 Yr.Av: 84 Rank: #36/100

4 Yr. Av.: 84 Rank: #39/96

For the Medical School: The clock hour is the basis of unit credit; 100 hours equal 1 unit; the second year is 9 months long and 4 years of approximately 12 units each are required for graduati grades are numerals 75 - 100 with 75 as the lowest passing grade which is also required for yearly progression and graduation. For the Graduate School: The unit of credit is the semester ho passing grades are A, B, C. "X" denotes incomplete work and "Q" denotes a course dropped with no penalty. Honorable dismissal is granted unless stated otherwise.

Washington State Department of Health

Washington State Medical Quality Assurance Commission
Applicant's Professional Liability Action History

Applicants name: Louis Jerry Edwards Today's Date: 9/28/98

Please submit a ***separate form for each past or current professional liability claim or lawsuit*** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

Date of occurrence:: June 12 1990 Details: I did a voluntary first trimester abortion on this patient. She was subsequently treated by another physician and a small amount (<10gm) tissue was removed. The patient had a complete recovery with no residual effects.

Case: Bailey, Carol L. vs Edwards, Jerry, Cause no. 92-53879, 215th Judicial District Court of Harris County, Texas.

2) Date suit or claim was filed: 11/25/1992 Name and Address of Insurance Carrier that handled the claim: APT, 1301 Capitol of Texas Hwy, Austin Texas 78746

3) Your status in the legal action (primary defendant, co-defendant, other): Primary defendant

4) Current status of suite or other action: dismissed in Summary Judgement

5) Date of settlement, judgment, or dismissal: June 21, 1993

6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. (**You must enclose a copy of final disposition of case.**) $ -0-

I verify the information contained in this form is correct and complete to the best of my knowledge:

Louis Jerry Edwards 9/28/98

Signature **Date**

NO. 92-53879

CAROL L. BAILEY

v.

JERRY EDWARDS, M.D.

IN THE DISTRICT COURT OF

HARRIS COUNTY, TEXAS

215TH JUDICIAL DISTRICT

ORDER

BE IT REMEMBERED that on the 21st day of June, 1993, the Court considered and heard Plaintiff's Motion for New Hearing on Defendant's Motion for Summary Judgment, and the Court, after reviewing the pleadings, the Motions, and hearing the arguments of counsel, was of the opinion that said motion should be DENIED. It is therefore,

ORDERED that Plaintiff's Motion to reconsider Defendant's Motion for Summary Judgment is hereby DENIED.

Signed this 12th day of July, 1993.

JUDGE PRESIDING

V7478 P0673

RECEIVED
SEP 10 1993
1 MDM

RECORDER'S MEMORANDUM:
This instrument is of poor quality and not satisfactory for photographic recordation, and/or alterations were present at the time of filming.

STATE OF TEXAS
COUNTY OF HARRIS

I, Katherine Tyra, District Clerk of Harris County, Texas, do hereby certify that the foregoing is a true and correct copy of the original record, now in my lawful custody and possession, as appears of record in Vol. 2428 Page 63 Minutes of said court on file in my office.

Witness my official hand and seal of office, this

AUG 25 1993

KATHERINE TYRA, DISTRICT CLERK
Harris County, Texas

By _____ Deputy

Washington State Department of Health

Washington State Medical Quality Assurance Commission
Applicant's Professional Liability Action History

Applicants name: Louis Jerry Edwards Today's Date: 9/28/98

Please submit a ***separate form for each past or current professional liability claim or lawsuit*** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

Date of occurrence:: September 1990 Details: I did A Laprosopic Surgery on this patient for an ectopic pregnancy. She subsequently had to be Treated by me with Methotrexate for Residual Trophoblastic Tissue. Motion for Non-Suit was filed by the plaintiff and the case was dismissed. The patient had a full Recovery.
Case: Gloria Alonzo vs Jerry L. Edwards, Cause 91-62733 333rd Judicial District Court of Harris County TX.

2) Date suit or claim was filed: 12/91 Name and Address of Insurance Carrier that handled the claim: API, 1301 Capitol of Texas Hwy, Austin TX 78746

3) Your status in the legal action (primary defendant, co-defendant, other): Primary defendant

4) Current status of suite or other action: dismissed after motion for Non-Suit by plaintiff

5) Date of settlement, judgment, or dismissal: June 9, 1993

6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. **(You must enclose a copy of final disposition of case.)** $ 0

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature

9-28-98
Date

NO. 91-52[illegible]

GLORIA ALONZO	•	IN THE DISTRICT COURT OF
VS.	•	HARRIS COUNTY, TEXAS
JERRY L. EDWARDS, M.D.	•	333RD JUDICIAL DISTRICT

ORDER OF DISMISSAL

CAME TO BE HEARD Plaintiff GLORIA ALONZO's Motion for Non-Suit of the Defendant, JERRY L. EDWARDS, M.D.. After consideration of the evidence, this Court is of the opinion that said motion should in all things be GRANTED.

IT IS, THEREFORE, ORDERED, ADJUDGED AND DECREED that this cause of action be and is hereby dismissed, without prejudice to the refiling of same, against the Defendant JERRY L. EDWARDS, M.D..

SIGNED this the 9th day of June, 1993.

JUDGE PRESIDING

[illegible] 0214

STATE OF TEXAS
COUNTY OF HARRIS

I, Katherine Tyra, District Clerk of Harris County, Texas, do hereby certify that the foregoing is a true and correct copy of the original record, now in my lawful custody and possession, as appears of record in Vol. ___, Page ___, Minutes of said court on file in my office

Witness my official hand and seal of office, this

KATHERINE TYRA, DISTRICT CLERK
Harris County, Texas
By

S. BATTS

THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL SCHOOL

STUDENT'S PERMANENT RECORD -- DALLAS, TEXAS

Name Mrs. Mr. Miss: Edwards, Louis Jerry

M.D. Degree Received June 2, 1969

Internship: Ben Taub Children's Hosp., Houston, Texas

Dallas Address: 3930 Holland

Date of Birth: March 24, 1942

Place of Birth: Dallas, Texas

Parent's Full Name: Louis G. Edwards

Church Affiliation: Baptist

Parent's Address: Box 1101 Kermit, Texas

Married? No; yes

Preparatory School: Kermit HS, Kermit

Date of graduation: 1960

Last College Attended: U of Texas; Rice University

Degree: B.A. Year 1964

Military Status: Veteran? No Air Force..... Army..... Navy.....

First Year Date: 9-13-65 / 6-4-66			Second Year Date: 9-12-66/6/3/67			Third Year Date: 9-11-67/6-1-68			Fourth Year Date: 9/9/68-5/31/69		
COURSE	GRADE	CREDIT	COURSE	GRADE	CREDIT	COURSE	GRADE	CREDIT	COURSE	GRADE	CREDI
GROSS ANATOMY	81	3	INTROD. TO MEDICINE	92	2	MEDICINE	81	8	OBSTETRICS-GYNECOLOGY	85	2
MICROANATOMY	88	2	MICROBIOLOGY	82	2.	OBSTETRICS-GYNECOLOGY	87	2	PEDIATRICS	92	2
NEURO-ANATOMY & PHYSIOLOGY	86	1.5	PATHOLOGY (GENERAL))	86	4	PEDIATRICS	84	2	PSYCHIATRY	91	2
BIOCHEMISTRY	86	2	CLINICAL PATHOLOGY)			SURGERY	90	1.5	SURGERY.	80	5
BIOPHYSICS	90	0.5	PHARMACOLOGY	86	2						
PHYSIOLOGY	85	3	PREVENTIVE MED & PUB. HEALTH	88	0.5						
PSYCHIATRY	86	0.5	PSYCHIATRY	83	0.5						

Gen Av.: 85 Rank In Class: Up.3d/101 | Gen Av.: 86 Rank In Class: Mid.3d/98 | Gen Av.: 83 Rank In Class: #56/100 | Gen Av.: 85 Rank in Class: #67/96

11-65 500

3 Yr.Av: 84 Rank: #36/100 | 4 Yr. Av.: 84 Rank: #39/96

AMA/NCVS

MAR 8 1994

3-1-94 Date

For the Medical School: The clock hour is the basis of unit credit; 100 hours equal 1 unit; the second year is 9 months long and 4 years of approximately 12 units each are required for graduati grades are numerals 75 - 100 with 75 as the lowest passing grade which is also required for yearly progression and graduation. **For the Graduate School:** The unit of credit is the semester ho passing grades are A, B, C. "X" denotes incomplete work and "Q" denotes a course dropped with no penalty. Honorable dismissal is granted unless stated otherwise.

NATIONAL BOARD OF MEDICAL EXAMINERS®

Record of Scores and Endorsement of Certification

This document was prepared by
National Board of Medical Examiners (NBME)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

Recipient: Washington Bd Med Exam
Department of Health
1300 Quince Street
MS: EY-25
Olympia, WA 98504

Date: 10/06/1998

Examinee: Louis Jerry Edwards

Examinee ID: 3-104-914-1
Date of Birth: 03/24/1942

NBME Certification Date: 07/01/1970

Certificate#: 104914

This record shows only NBME passing scores for each NBME examination reported on this document unless a complete NBME examination history has been requested by the examinee. If applicable, also results for USMLE Steps taken by this examinee (and for which scores have been reported to date) are shown.

This examinee has successfully completed the examination, education and training requirements for NBME certification.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores: Anat	Phys	Bioc	Path	Micr	Phar
06/1967	Pass	Three-Digit								
		Two-Digit	86.2	(75)	87	90	87	86	86	81

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores: Med	Surg	ObGyn	PM/PH	Peds	Psych
04/1969	Pass	Three-Digit								
		Two-Digit	88	(75)	85	81	88	89	92	94

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/1970	Pass	Three-Digit		
		Two-Digit	83.5	(75)

*** END OF DOCUMENT ***

See reverse side for explanation of information reported above.

WA0294

Authenticity of NBME Record of Scores

Original, certified copies of the NBME Record of Scores are printed on green safety paper and are produced only by the NBME. The embossed NBME seal in the lower left corner certifies the authenticity of this document. Alteration or forgery of the NBME Record of Scores may result in appropriate legal action or other action consistent with NBME or USMLE policies.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on a scale with a mean of 200 and a standard deviation of 20, in increments of 1. Most scores fall between 150 and 250.

All NBME Part III Examinations

The most recent total test score is reported. This score is on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

Two-Digit NBME Scores

For all NBME scores, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

USMLE Step 1, Step 2 and Step 3

Reports of scores on USMLE include a complete score history, and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For recent administrations, the mean and standard deviation of scores on the three-digit scale for first-time examinees from medical schools in the United States are approximately 205 and 20, respectively, and most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 82 on the two-digit scale is equivalent to a score of 200 on the three-digit scale. A score of 75 on the two-digit scale is always the minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each Step of USMLE is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 6 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Special circumstances in connection with the administration of USMLE may result in one of the following annotations being listed next to the score for that examination:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

Incomplete - The examinee sat for some but not all of the scheduled test books. **No score is reported.**

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* To obtain information regarding the nature of the irregular behavior, the full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Testing Accommodations - Following review and approval of a request from the examinee, testing accommodations were provided in the administration of the examination.

BAYLOR COLLEGE OF MEDICINE
Office of House Staff Education
Department of Pediatrics
One Baylor Plaza
Houston, Texas 77030

BEN TAUB GENERAL HOSPITAL

Texas Children's Hospital
(713) 770-1170
(800) 662-9664
FAX: (713) 770-1187

October 19, 1998

Medical Quality Assurance Commission
1300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504

Dear Credentialing Specialist:

Thank you for your request for professional reference/verification of training for Dr. Louis Edwards. We regret that the volume of work in this regard precludes us from completing different forms for each institution. We ask that you accept the enclosed information and verification in lieu of your own form. If this is not agreeable, please return your form to us, but allow at least 25 working days for completion.

Thank you.

Sincerely,

Martin I. Lorin, M.D.
Professor of Pediatrics
Vice Chairman for Educational Affairs and
Director of House Staff Education

/dl

Enclosure

VERIFICATION OF PEDIATRIC RESIDENCY TRAINING
Baylor Affiliated Hospitals Pediatric Residency Program
Department of Pediatrics, Baylor College of Medicine
One Baylor Plaza, Houston, Texas 77030
713-770-1171 FAX 713-770-1187

1. Name: Louis Edwards , M.D.

2. Straight Pediatrics: ___X___ Medicine/Pediatrics: _____
   Other: _____

3. Dates of training at Baylor College of Medicine. This program is approved by the ACGME.

   Internship: 7/1/69 - 6/30/70
   Residency:

4. Completed above training: Yes ___X___ No _____

5. Performance:

	Satisfactory	Unsatisfactory	No Information
Basic medical knowledge	X		
Professional judgement	X		
Sense of responsibility	X		
Ethical Conduct	X		
Clinical competence and technical skill	X		
Cooperativeness, ability to work with others	X		
Patient management	X		
Medical record currency and quality	X		
Relationship with professional staff	X		
Physician-patient relationships	X		

To the best of my knowledge, the applicant, by virtue of the training and experience in this program, IS ___X___ / IS NOT _____ qualified to be approved for privileges in **PEDIATRICS.** This evaluation is based on demonstrated performance compared to that reasonably expected of a practitioner at his/her level of training, experience and background.

6. Physical and Mental Health:

   To the best of my knowledge, during this period of training, the applicant DID _____ / DID NOT ___X___ display any mental conditions that interferred with his/her practice in any way, including problems with alcohol or drug dependency.

7. Actions Taken:

   To the best of my knowledge, during this period of training, the applicant WAS _____ / WAS NOT ___X___

   a. found guilty of fraud or dishonesty
   b. found guilty of unprofessional conduct
   c. disciplined by a licensing agency
   d. denied or asked to surrender a Federal or State controlled substances permit
   e. arrested, fined, charged with or convicted of a crime, indicted, imprisoned or placed on probation
   f. a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in his/her behalf or paid such a claim themself

8. Recommendation:

   a. Recommend without reservation ___X___
   b. Recommend with reservation _____
   c. Do not recommend _____

9. Comments:

   Dr. Louis Edwards was excellent.

Martin I. Lorin, M.D.
Director, House Staff Education

Date: 11/4/98

Please note, any requests for subspecialty privileges must be based on training received after completion of the pediatric residency and cannot be addressed or verified by this office. Please contact the appropriate source of such training (fellowship) for information in this regard.

Health

MD

TO: **Post Graduate Training Program Director**

Baylor College of Medicine
FACILITY NAME

One Baylor Plaza - Room S-102
ADDRESS

Houston, TX 77030

RE: Verification/Evaluation of Training

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address show below. **All questions must be answered.**

Louis Jerry Edwards
APPLICANT (PRINT OR TYPE)

3/24/42
BIRTHDATE

Louis Jerry Edwards
SIGNATURE OF APPLICANT

1. Louis Edwards is or was engaged in post-graduate training in our program

from 7-1-69 to 6-30-70
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

in the field of Pediatrics to _____

2. **Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evaluations conducted.)** _____

3. **Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program?** ☐ Yes ☒ No If yes, please explain _____

4. **Is there anything in the participant's file which would indicate he/she would be unable to safely practice medicine?** ☐ Yes ☒ No **If yes, please provide documentation.**

5. We would appreciate any further documentation you feel would assist in the evaluation process. Thank you.

Return to:
Medical Quality Assurance Commission
1300 SE Quince Street
P O Box 47866
Olympia, WA 98504-7866
(360) 753-2844 (A-L)
(360) 664-3909 (M-Z)

(Seal)

Signature _____
Title _____
Hospital _____
PLEASE TYPE OR PRINT
Address _____
_____
Date _____
Telephone _____

DOH 657-034 (Rev 1/98)

Health

MD

DELIVERED
NOV 20 1998
Section 5

TO: **Post Graduate Training Program Director**

Baylor College of Medicine
FACILITY NAME

One Baylor Plaza, Room S-102
ADDRESS

Houston, TX 77030

RE: Verification/Evaluation of Training

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address show below. **All questions must be answered.**

Louis Jerry Edwards
APPLICANT (PRINT OR TYPE)

3/24/42
BIRTHDATE

Louis Jerry Edwards
SIGNATURE OF APPLICANT

1. L. Jerry Edwards, M.D. is or was engaged in post-graduate training in our program

from Internship 1969-70 to Residency 1970-72 and 1975-77
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

in the field of Obstetrics/Gynecology to _____

2. **Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evaluations conducted.)** His performance was effective, competent and dependable.

3. **Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program?** ☐ Yes ☒ No If yes, please explain _____

4. **Is there anything in the participant's file which would indicate he/she would be unable to safely practice medicine?** ☐ Yes ☒ No If yes, please provide documentation.

5. We would appreciate any further documentation you feel would assist in the evaluation process. Thank you.

Return to:
Medical Quality Assurance Commission
1300 SE Quince Street
P O Box 47866
Olympia, WA 98504-7866
(360) 753-2844 (A-L)
(360) 664-3909 (M-Z)

(Seal)

Signature RMalinak MD
Title Residency Prog. Dir. L. Russell Malinak, M.D.
Hospital Baylor College of Medicine
Address 6550 Fannin, Suite 701 PLEASE TYPE OR PRINT
Houston, Texas 77030
Date November 13, 1998
Telephone 713-798-7500

DOH 657-034 (Rev 1/98)

Texas State Board of Medical Examiners

333 Guadalupe • Tower 3 • Suite 610 • Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

October 19, 1998

recieved in UT by mistake?

DELIVERED
NOV 05 1998
Section 5

WASHINGTON QUALITY
MEDICAL ASSURANCE COMMISSION
1300 SE QUINCE STREET
PO BOX 47866
OLYMPIA WA 98504-7866

RE: LOUIS JERRY EDWARDS, MD
D5977

To Whom It May Concern:

In addition to the licensure verification information provided by our Registration Division, the Texas Medical Practice Act, Section 4.05(c), allows limited disclosure of investigative information to other state licensing boards. A review of our data indicates that the following allegation(s) have been or are being investigated.:

File # 92-0099 was opened for an allegation of unprofessional conduct and was closed for lack of sufficient evidence on 3/6/92.

Any investigational information, which is not specifically authorized for release to other state medical licensing authorities, is privileged and not subject to disclosure. Board investigative reports or investigative memoranda, the identity of nontestifying complainants, attorney-client communications, attorney work product, or other materials covered by a privilege as recognized by the Texas Rules of Civil Procedure or the Texas Rules of Civil Evidence may not be provided to you except in extremely limited circumstances. Effective September 1, 1987, by policy and statute, all physicians are notified of the initiation of an investigation unless that notification may jeopardize an investigation. All physicians are notified upon the completion of an investigation. If your licensure process requires more information concerning the above allegations, it is suggested that you consult with the physician.

We trust this information is of assistance to you.

Sincerely,

Lloyd E. McRae, Director
Investigations Department
LEM:mlb

Texas State Board of Medical Examiners

333 Guadalupe • Tower 3 • Suite 610 • Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

DELIVERED
OCT 05 1998
Section 5

SEPTEMBER 29, 1998

WASHINGTON QUALITY
MEDICAL ASSURANCE COMMISSION
1300 S.E. QUINCE ST.
P.O. BOX 47866
OLYMPIA, WA 98504-7866

For: WASHINGTON QUALITY MEDICAL ASSURANCE COMMISSION

In response to a recent request, we verify the following information:

****

Physician:	LOUIS JERRY EDWARDS, MD
License:	D5977
Date Issued:	08-27-1969
Licensed By:	Examination
Date of Birth:	03-24-1942
Medical School:	UNIV OF TEXAS, SOUTHWESTERN MED SCH, DALLAS
Graduation Year:	1969
Permit Expires:	11-30-1998

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

Investigation Status:

If any information is available, it has been attached to this letter.

****

If you have any further questions, please contact the Verification division.

Sincerely,

Staci L. Gilbreath
Verification Division

BOARD SEAL

VERIFICATION OF UTAH LICENSURE

Division of Occupational & Professional Licensing
160 East 300 South
BOX 146741
Salt Lake City, Utah 84114-6741

Name of Licensee (as it appears in our records):

EDWARDS, LOUIS JERRY

DELIVERED
OCT 05 1998
Health Professions
Section 5

Date of Birth: 03-24-42

Soc Sec #: 1 - DOH Licensee Social Sec...

Classification of License Issued: PHYSICIAN AND SURGEON

License Number: 94-272536-1205

Current Status: ACTIVE IN GOOD STANDING

Original Date of Licensure: 05-11-94

Expiration Date: 01-31-00

Disciplinary Action:

[✓] No

[] Yes, certified copies of all Petitions and Orders are attached

Signature: Kelly L Stones

Title: LICENSING SPECIALIST

Date: October 1, 1998

(SEAL)

To expedite the verification process, the above is the only format used by the Utah Division of Occupational and Professional Licensing

Health

MD

TO: **Hospital Administration**

Womens Hospital of Texas
HOSPITAL NAME

7600 Fannin
ADDRESS

Houston, TX 77054

DELIVERED
OCT 12 1998
Section 5

RE: Verification and Evaluation of Privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am therefore authorizing the release of and would appreciate you providing the appropriate information **directly** to the address show below at your earliest convenience. **All questions must be answered.**

Louis Jerry Edwards
APPLICANT (PRINT OR TYPE)

3/24/42
BIRTHDATE

Louis Jerry Edwards
SIGNATURE OF APPLICANT

1. _____ now has/has had admitting or specialty privileges at this hospital

from _____ to _____
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. **Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?** ☐ Yes ☐ No

If yes, please explain _____

3. **Has the applicant ever been asked to resig**

4. **Is there any information in your files which**

☐ Yes ☐ No If yes, please explain

5. We would appreciate any information you feel v

Return to:
Medical Quality Assurance Commission
1300 SE Quince Street
P O Box 47866
Olympia, WA 98504-7866
(360) 753-2844 (A-L)
(360) 664-3909 (M-Z)

(Seal)

WOMAN'S HOSPITAL OF TEXAS

The referenced practitioner is/was a member in good standing of the Medical Staff of Woman's Hospital of Texas:

Staff Status: Inactive

Appointment from: 7/27/82 to: 8/27/98

Specialty: Gynecology

Verified: Lisa Foster
Medical Staff Services

Date: 10/6/98

DOH 657-017 (Rev 1/98)

Health

MD

TO: **Hospital Administration**

Ben Taub Hospital
HOSPITAL NAME

1504 Taub Loop
ADDRESS

Houston, TX 77030

DELIVERED
OCT 08 1998
Section 5

RE: Verification and Evaluation of Privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am therefore authorizing the release of and would appreciate you providing the appropriate information **directly** to the address show below at your earliest convenience. **All questions must be answered.**

Louis Jerry Edwards 0B16V 3/24/42
APPLICANT (PRINT OR TYPE) BIRTHDATE

SIGNATURE OF APPLICANT

1. _____ now has/has had admitting or specialty privileges at this hospital

from _____ to _____
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. **Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?** ☐ Yes ☐ No

If yes, please explain _____

3. **Has the applicant ever been asked to resign?** ☐ Yes ☐ No If yes, please explain _____

4. **Is there any information in your files which v**

☐ Yes ☐ No If yes, please explain ____

5. We would appreciate any information you feel v

Return to:
Medical Quality Assurance Commission
1300 SE Quince Street
P O Box 47866
Olympia, WA 98504-7866
(360) 753-2844 (A-L)
(360) 664-3909 (M-Z)

(Seal)

RECEIVED
SEP 30 1998
DOH 657-017 (Rev 1/98)
PHYSICIAN SERVICES
BEN TAUB GENERAL HOSPITAL

HARRIS COUNTY HOSPITAL DISTRICT

The referenced practitioner is/was a member in good standing of the Medical Staff of the Harris County Hospital District as follows:

Staff Status: Active St Aff

Appointed from: 02-16-87 to Present

Service/Sec: OBG.

Verified: Linda Matthews
(Physician Services Administration)

Date: 10-2-98

Address _____

Date _____

Telephone _____

Washington State Department of Health

DELIVERED
OCT 08 1998
Health Professions
Section 5

MD

RECEIVED
OCT 01 1998
By

TO THE APPLICANT

Complete the identifying information below and submit to:

Federation of State Medical Boards
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3855

Department of Health
Medical Quality Assurance Commission
1300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504-7866

Date: 9/24/98

I am applying for licensure to practice medicine in the state of Washington. Please indicate on the lower portion of this letter if there is any previous or pending disciplinary action against my license(s) and send this information directly to the Washington State Medical Quality Assurance Commission. Thank you for your assistance.

NAME: Louis Jerry Edwards

SSN: 1 - DOH Licensee Social Security Number - RCW 42.56.350(1)

MEDICAL SCHOOL: U. of Texas Southwestern U

YEAR OF GRADUATION: 1969

BIRTHDATE: 3/24/42

RESPONSE:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

OCT 2 1998

James R. Winn, M.D.

JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

DOH 657-072 (Rev 1/98)

WA

American Medical Association

Physicians dedicated to the health of America

Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

Name and Address:

LOUIS JERRY EDWARDS MD
PO BOX 981892
PARK CITY UT 84098 USA

Phone: 713-578-5479
Birthdate: 03/24/1942
Birthplace: DALLAS TX USA

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Self Designated Practice Specialties (SDPS):

Primary: GYNECOLOGY
Secondary: UNSPECIFIED

AMA membership: PENDING MEMBER

Following Data Provided by the Primary Sources

Medical School:
UNIV OF TX SOUTHWESTERN MED CTR AT DALLAS, MED SCH, DALLAS TX 75235 (VERIFIED)

Year of Graduation: 1969 (VERIFIED)

Current and/or Prior Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Institution:	BAYLOR COLL OF MED	**State:** TEXAS
Specialty :	OBSTETRICS AND GYNECOLOGY	10/1970 - 06/1977 (VERIFIED)
Institution:	BAYLOR COLL OF MED	**State:** TEXAS
Specialty :	OBSTETRICS AND GYNECOLOGY	07/1970 - 06/1972 (VERIFIED)
Institution:	BAYLOR COLL OF MED	**State:** TEXAS
Specialty :	OBSTETRICS AND GYNECOLOGY	07/1969 - 06/1970 (VERIFIED)

Note: Additional information, used for appointments and privileges, is not solicited, nor is it received from the residency program directors. If additional information is required, please contact the program director(s).

National Board of Medical Examiners (NBME) Certification Year: MD: 1970

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency: **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited unless otherwise agreed to in writing by the AMA.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties either, expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.

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Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

License(s) : State	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
UTAH	MD	05/11/1994	01/31/2000	ACTIVE	UNLIMITED	07/31/1998
TEXAS	MD	08/27/1969	11/30/1998	ACTIVE	UNLIMITED	09/02/1998

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. A blank expiration date indicates that the data is not provided to AMA by the licensing board. Please contact the appropriate licensing board directly for this information.

ECFMG Certfication:

Applicant Number:

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

Federal Drug Enforcement Administration:

AS OF 7/7/98 FEDERAL DEA REGISTRATION IS VALID.

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority as the AMA does not maintain this information.

Specialty Board Certification(s):

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

Primary Board: AM BRD OF OBSTETRICS AND GYNECOLOGY
Effective: 01/1980 **Expires:** INITIAL CERTIFICATION
Subcertification or Certificate of Special Competence: NONE REPORTED TO DATE
Effective: **Expires:**

Note: For certfication dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency: **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited unless otherwise agreed to in writing by the AMA.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties either, expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.

American Medical Association

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Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the Physician Profile is intended as an instrument to assist with credentialing. Appropriate use of the Physician Masterfile data contained on this profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, residency training and board certification.

If you note any discrepancies, please mark them on a copy of the profile and return to: American Medical Association Department of Data Services, 515 N. State Street, Chicago, Il 60610.

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency: **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited unless otherwise agreed to in writing by the AMA.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

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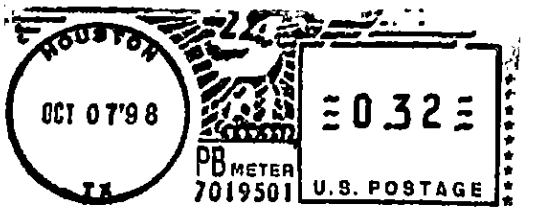
COLUMBIA
Woman's Hospital of Texas

7600 Fannin
Houston, Texas 77054



Medical Quality Assurance Commission
1300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504-7866

State of Utah
DEPARTMENT OF COMMERCE
DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

Heber M. Wells Building
160 East 300 South
P O Box 146741
Salt Lake City UT 84114-6741

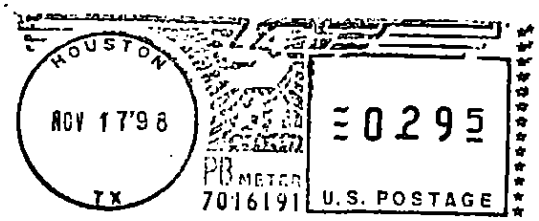
RETURN SERVICE REQUESTED

SALT LAKE CITY UT NOV - 3'98 U.S.POSTAGE $0.32

38304/7864

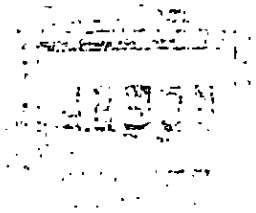
BAYLOR COLLEGE OF MEDICINE
Department of Obstetrics and Gynecology
Residency Academic Office 105110
One Baylor Plaza
Houston, Texas 77030-3498

PRESORTED
FIRST CLASS



Medical Quality Assurance Commission
1300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504-7866

AUTO 98504



BAYLOR COLLEGE OF MEDICINE
One Baylor Plaza
Houston, Texas 77030-3498

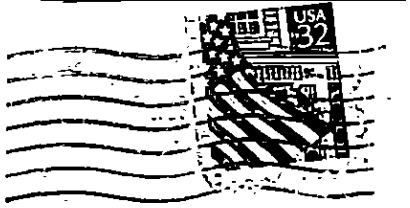
Martin I. Lorin, M.D.
Pediatric House Staff Education
Baylor College of Medicine
6621 Fannin, MC 1-1000
Houston, TX 77030

ADDRESS SERVICE REQUESTED

HOUSTON NOV 05'98 TX
PB METER 7025374
=0.43= U.S. POSTAGE

Medical Quality Assurance Commission
1300 SE Quince Street
P. O. Box 47866
Olympia, WA 98504-7866

Jerry Edwards
5606 St Paul
Bellaire, Tx 77401



Betty Elliott
Program Representative
State of Washington, Department of Health
1300 SE Quuince St
P.O. Box 47866
Olympia, Wa 98504-7866

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1309 SE Quince St • P.O. Box 47866 • Olympia, WA 98504-7866

October 6, 1998

Louis Edwards, MD
POB 981892
2305 Red Pine Rd
Park City, UT 84098

Dear Dr. Edwards

This is to acknowledge receipt of your application to obtain licensure as a physician and Surgeon in the state of Washingtion.

Your application was received on **October 2, 1998.**

MISSING ITEMS: American Medical Association, Federation of State Medical Boards, Scores, Post Graduate training, Hospital verification, Medical School Transcripts, Missing Chronology (6/70-10/70, 6/72-11/75

A deficiency letter will be sent every four to five weeks until the application is considered complete. Please understand Commission staff process a considerable amount of application files at any given time. Deficiency letters are our way of notifying you what is lacking in your file. An over abundance of phone calls simply slow the process down as it diverts staff resources from application processing. We appreciate your consideration of staff resources and your patience with the process.

Depending on the complexity of the application file, the review process may take 3 to 5 working days for routine applications, an additional 14 working days for applications considered non-routine that must be reviewed by a Commission Member, or, if your application contains derogatory or disciplinary information, it may need to be reviewed by the Full Commission at a Commission meeting for final disposition, in which case the processing time will be longer.

If you have any questions, please feel free to contact me at (360) 753-2844.

Sincerely,

Betty Elliott,
Program Representative

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
1300 SE Quince St • P.O. Box 47866 • Olympia, WA 98504-7866

December 15, 1998

Louis Edwards, MD
POB 981892
2305 Red pine Rd
Park City, UT 84098

Dear Dr Edwards

As of this date, our records indicate the following items still have not been received. In order for us to continue processing your application we will need the following:

Missing Chronology 6/70-10/70, 6/72-11/75
Medical School Transcripts
Post Graduate training received verification, but only years, need months of attendance, if you have certificates, you may submit copies

Upon receipt of the above mentioned items, your application will be considered complete and will begin the review process.

If you have any questions, please contact me at (360) 236-4785

Sincerely,

Betty Elliott
Program Reprsentative

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
1300 SE Quince St • P.O. Box 47866 • Olympia, WA 98504-7866

January 22, 1999

Louis Edwards, MD
5606 St Paul
Bellaire, TX 77401

Dear Dr Edwards

As of this date, our records indicate the following items still have not been received. In order for us to continue processing your application we will need the following:

Medical School Transcripts

Upon receipt of the above mentioned items, your application will be considered complete and will begin the review process.

If you have any questions, please contact me at (360) 236-4785

Sincerely,

Betty Elliott
Program Reprsentative

Application File_330719_pdf-r.pdf redacted on: Tuesday, April 22, 2014

Redaction Summary (6 redactions)

1 Privilege / Exemption reason used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (6 instances)

Page 7, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 11, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 16, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 17, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 34, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 37, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance