STATE OF WASHINGTON
DEPARTMENT OF LICENSING
DIVISION OF PROFESSIONAL LICENSING
P.O. Box 9649
Olympia, WA 98504

24164
8-22-86
3-1-87

FOR VALIDATION ONLY

9170 070 080586 75.00

APPLICATION FOR

LICENSE TO PRACTICE MEDICINE

MAKE REMITTANCE IN U.S. FUNDS PAYABLE TO: STATE TREASURER

FOR OFFICE USE ONLY

CERTIFICATE NO. _____ ISSUE DATE _____ EXPIRATION DATE _____

Application for licensure is made by: (Check one)

- ☐ National Board Waiver
- ☒ FLEX Examination Waiver
  - FLEX Identification Number (FIN) _____
- ☐ Endorsement of state examination
  - State _____
- ☐ FLEX examination
  - Date of examination requested (Month and Year) _____

FOR OFFICE USE ONLY

PROG (1)	TRANS (3)	PROF CODE (4)	PIC/CIC (5)		EXPIRATION DATE (9)	EXPT (10)	STAT (11)	TYPE (12)
LA		252-	ARNOLSJ505DA				4	

KEY DATE (13)	CLASS (14)	ASSN (15)	BILLED AMOUNT (16)	SIGN	SPLIT	QRTD

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME (20) ARNOLD (LAST) SARA (FIRST) JANE (MIDDLE)

ADDRESS (21) 4048 Cascadia South

CITY (24) Seattle STATE (25) WA ZIP (26) 98118 COUNTY (27) King

TELEPHONE NUMBER (Work) (39) 206-543-0482

SOCIAL SECURITY NUMBER (40) 1 - DOH Licensee Soci...
Requested for identification purposes only. Entering SSN is voluntary and is not required for licensing approval.

TELEPHONE NUMBER (Home) 722-4685

SEX (F or M) F BIRTHDATE 03 (Mo.) 01 (Day) 50 (Yr.)

BIRTHPLACE Vienna (City) Austria (State/County)

MEDICAL SPECIALITY Family Medicine

FOR OFFICE USE ONLY

Exam Date (42) ___/___/___
Voter Dist. (46) ___
Grad Yr/Sch (48) _____

MEDICAL SCHOOL University of North Carolina, USA (Name/Country) YEAR GRADUATED 1980

Have you previously applied for a Washington state medical license or limited license? ..... ☐ YES ☒ NO

List other name(s) that appear on documents or credentials Possibly, "Sara Arnold Fowler" appears on my medical school transcript.

IDENTIFICATION

HEIGHT	WEIGHT
5'2"	125
COLOR OF EYES	COLOR OF HAIR
blue	brown

PERSONAL DATA

	YES	NO
1. Have you ever been called before any state or provincial licensing board for interrogation concerning any violation of the laws or regulations pertaining to the profession for which you are applying, or for unethical conduct?	☐	☒
2. Have you ever had a license to practice revoked, suspended, or restricted?	☐	☒
3. Have you ever been denied a license or the right to take an examination for licensing in any state, province, or country?	☐	☒
4. Have you ever had hospital privileges or medical society membership revoked, suspended, or restricted on grounds of unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment?	☐	☒

If the answer to any of the above questions is YES, enclose a letter naming the state, hospital or society, the date of the action, the cause, and the nature of the decision.

5. Have you ever been convicted of or plead guilty to a felony or misdemeanor other than minor traffic offenses?	☐	☒
6. Have you ever been convicted of a violation of any state or federal controlled substance act, or any drug or narcotic law?	☐	☒

If the answer to questions 5 or 6 is YES, please enclose a letter giving the date, jurisdiction, and nature of the conviction, as well as the sentence imposed. If still on parole or probation, provide the name and address of the supervising officer.

7. Have you ever used any legend drug, or controlled substance (including Schedule 1) for other than therapeutic purposes?	☐	☒
8. Have you ever been addicted to or treated for addiction to or abuse of any controlled substance, drug or chemical?	☐	☒
9. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism?	☐	☒
10. Have you ever received psychiatric therapy or received treatment for a mental illness, except as related to psychiatric training?	☐	☒
11. Are you presently suffering from any disability or illness (mental or physical) which could affect your ability to safely practice medicine?	☐	☒

If the answer to any of questions 7 through 11 is YES, please enclose a letter giving details of your use, condition or addiction. Include the name and address of the treating professional and/or institution. In addition, request a letter from the treating physician indicating diagnosis, treatment and prognosis.

12. Have you been named in any malpractice suits alleging your incompetence or negligence in the practice of medicine? Include the nature of the case, date, and summarize care given. Enclose a copy of the original complaint and settlement or final disposition. If pending, please indicate the status.	☐	☒

FAILURE TO GIVE COMPLETE AND TRUE INFORMATION CONSTITUTES CAUSE FOR DENIAL OF YOUR APPLICATION FOR LICENSURE

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training.

Schools Attended — Location If other than U.S., Quote names of schools in original language and translate to English.	Number Of Years Attended	Attendance				Diploma or degree obtained Quote titles in original language and translate to English
		Entrance		Leaving		
		Class/ Grade	Date Mo/Yr	Cls/Grd Cmplt.	Date Mo/Yr	
Secondary or High School						
Malden High School Malden, Missouri	four	ninth	9/63	twelfth	6/67	high school diploma
Post Secondary Study (Exclusive of Medical School)						
I attended college in Tennessee and Missouri from 9/67 to 1/70, taking general liberal arts courses. I quit college and did not return until 9/73, when I started pre-medical studies.						
Univ.N.C.,Chapel Hill,N.C.	2¼		9/73	12/75		BA, Chemistry
Medical Education (List all Medical Schools Attended)						
UNC School of Medicine Chapel Hill, N.C.	four		9/76		5/80	M.D.
Post-Graduate Training (List all programs attended)						
Family Medicine Residency Chapel Hill, NC	three		6/80		6/83	Board-certified, Family Medicine, July 1983
Occupational Medicine Res. NIOSH, Cincinnati Ohio	one		7/84		7/85	(Still need MPH, which I am currently doing, for occ. med. boards)

In chronological order list all professional experience received since graduation from medical school to the present. (Exclude activities listed under other sections.)

Indicate nature of experience or practice	Inclusive dates of experience	
	Beginning Mo/Yr	Ending Mo/Yr
Fellowship, Epidemic Intelligence Service (EIS), Centers for Disease Control, working at NIOSH, the National Institute for Occupational Safety & Health, Cincinnati, Ohio	7/83	7/85
	(concurrently enrolled in NIOSH occupational medicine residency listed above from 7/84-85,)	
During my 2 years at NIOSH, I saved my money so that I could live for a year without a salary, and took a "self-imposed sabbatical," travelling.	8/85	6/86
Robert Wood Johnson Family Medicine Faculty Development Fellowship, U. of WA, Seattle	6/86	6/88

List clinical clerkships completed as part of the medical school rotations (3rd and 4th years).

Exact Clerkship Dates	Clinical Area	Name and Location of Health Care Facility	Medical School Affiliation/Location
ON MEDICAL	SCHOOL TRANSCRIPT		

FIFTH PATHWAY

Name and Location of Medical School	Name and Location of Hospital	Inclusive Dates Attended
NOT APPLICABLE		

ECFMG CERTIFICATE/OTHER EXAMINATIONS

ECFMG Certificate Number	Date Examination Passed		Name of Specialty Boards	Date Received
	Medical	English		
NOT APPLICABLE				

Please list hospitals where privileges have been granted within the past five (5) years.

Name of Hospital and Location	Beginning Date Of Privileges Mo/Yr	Termination Date of Privileges Mo/Yr	Nature of Privileges
NOT APPLICABLE - THE ONLY HOSPITAL PRIVILEGES I HAVE HAD WERE AS A FAMILY MEDICINE			
RESIDENT.			

List all licenses to practice medicine obtained in other states or provinces of Canada. (Include whether active or inactive).

State or County	Date License Issued	Number	Basis of Licensure		Status of License Active/Inactive	Any Limitations on License
			Examination (Date Passed)	Endorsement		
North Carolina	Jan. 1983	26716	June 1980	FLEX	active	No

AFFIDAVIT

I, SARA JANE ARNOLD, being first duly sworn, depose and say that I am the
Print or type full name of applicant

person described and identified; that I am of good moral character; that I have not engaged in any of the acts prohibited by the statutes of the State of Washington; that I am the person named in the documents presented in support of this application; that I am the lawful holder of a medical diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentations.

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 Board any information, files or records required by the Board for its evaluation of my professional, ethical and physical qualifications for licensure in the State of Washington. I understand the Board may request a physical or mental evaluation to determine my fitness for practice.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice in the State of Washington.

Applicant's Signature Sara Jane Arnold

(SEAL) MARY JEAN LANTZ NOTARY PUBLIC COMMISSION EXPIRES MAR. 15, 1990 STATE OF WASHINGTON

Subscribed and sworn to before me this 18th day of July, 1986

Mary Jean Lantz,

Notary Public for the state of Washington

Residing at Seattle

My commission expires March 15, 1990.

WORKSHEET FOR MEDICAL LICENSURE APPLICATIONS

APPLICANT NAME _____

I. METHOD OF LICENSURE — SCORES REC'D

___ National Board Waiver
✓ FLEX Waiver — 84-00 ✓
___ Reciprocity _____

II. FEE RECEIVED — ✓
III. PHOTOGRAPH — ✓

IV. APPLICATION FORM

Personal data ✓
Chronology ✓
Affidavit ✓

V. SUPPORTING DOCUMENTS

Transcripts ✓

Post-graduate training programs

(✓) NC Memorial 6-80 to 6-83 — (✓) (F) UW 6-86 — (✓) NIOSH 7-83 to 7-85 (same)
( ) (F) NAT'L INST 7-83 to 7-85 — ( ) 7-84 to 7-85

Hospital privileges

( ) _____ ( ) _____ — X
( ) _____ ( ) _____
( ) _____ ( ) _____

State licenses

(✓) NC ( ) _____ ( ) _____ ( ) _____ — ✓ — ✓
( ) _____ ( ) _____ ( ) _____ ( ) _____

VI. FOREIGN GRADUATES

ECFMG Certificate — X
OR
Fifth Pathway — OR

AMA/DDB Clearance MLD 8-6-86 ✓

ADMINISTRATIVE RECOMMENDATION: _____

FINAL ACTION: ✓ APPROVED FOR LICENSE BY: ACS DATE: 8/22/86
BOARD REVIEW: _____ DENIED FOR LICENSURE BY: _____ DATE: _____

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 08-13-86
TIME: 9:35 PM

NAME: ARNOLD,SARA JANE, M.D.
ADDRESS: 4048 CASCADIA S
SEATTLE WA 98118
BIRTHPLACE: VIENNA/AUSTRIA
BIRTHDATE: 03/01/50
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL
UNIV OF NORTH CAROLINA AT CHAPEL HILL SCH MED; CHAPEL HILL NC 27514
YEAR OF GRADUATION: 1980
LICENSES (INITIAL YEAR GRANTED BY STATE):
NC 1980 (TEMPORARY)
NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE
SPECIALTY BOARD CERTIFICATION: AMERICAN BOARD OF FAMILY PRACTICE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: RESEARCH
SELF DESIGNATED SPECIALTIES
PRIMARY: FAMILY PRACTICE
SECONDARY: OCCUPATIONAL MEDICINE
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: FELLOW
HOSPITAL: UNIVERSITY HOSP SEATTLE WA 98195
DATES OF TRAINING: 10/85-09/86 -- (BEING CONFIRMED)
SPECIALTY: FAMILY PRACTICE
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: RESIDENT
HOSPITAL: NORTH CAROLINA MEM HOSP CHAPEL HILL NC 27514
DATES OF TRAINING: 07/81-06/83 -- (CONFIRMED)
SPECIALTY: FAMILY PRACTICE
SPECIALTY: UNSPECIFIED

HOSPITAL: NATL INST OCCUPAT-SAFETY HLTH CINCINNATI OH 45226
DATES OF TRAINING: 07/84-06/85 -- (CONFIRMED)
SPECIALTY: OCCUPATIONAL MEDICINE
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: INTERN
HOSPITAL: NORTH CAROLINA MEM HOSP CHAPEL HILL NC 27514
DATES OF TRAINING: 07/80-06/81 -- (CONFIRMED)
SPECIALTY: FAMILY PRACTICE
SPECIALTY: UNSPECIFIED

FELLOWSHIP: NONE REPORTED TO DATE

THE FOLLOWING IS HISTORICAL. CHECK WITH PRIMARY SOURCES FOR CURRENT STATUS:

NATIONAL SCIENTIFIC MEDICAL SOCIETIES:

(CONTINUED ON NEXT PAGE)

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; (3) THAT NO PROFILE INFORMATION WILL BE RELEASED, COPIED, EXTRACTED OR OTHERWISE USURPED FOR THE USE BY ANY OTHER PARTY, ENTITY, ORGANIZATION OR GOVERNMENT AGENCY; AND (4) THAT 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 PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 08-13-86
TIME: 9:35 PM

NAME: ARNOLD,SARA JANE, M.D. (CONTINUED)

AMERICAN COLLEGE OF PREVENTIVE MEDICINE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

 ****AMA FILES CHECKED

13

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; (3) THAT NO PROFILE INFORMATION WILL BE RELEASED, COPIED, EXTRACTED OR OTHERWISE USURPED FOR THE USE BY ANY OTHER PARTY, ENTITY, ORGANIZATION OR GOVERNMENT AGENCY; AND (4) THAT 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.

The Federation of State Medical Boards
of the United States
INCORPORATED

BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE PRESIDENT

2630 WEST FREEWAY, SUITE #138
FORT WORTH, TEXAS 76102-7199
(817) 335-1141

DALE G. BREADEN
ASSOCIATE EXECUTIVE VICE PRESIDENT

To: Washington Department of Licensing.

Subject: FLEX Scores

SARA JANE ARNOLD
4048 CASCADIA SOUTH
SEATTLE, WA
98118

Alternate Name(s)
FOWLER, SARA ARNOLD

It is certified that the named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: 500301003 Date of Certification: 08/13/86

EXAMINATION DATE:	06/80
FOR STATE:	134
STATE ID NUMBER:	00043

BASIC SCIENCE

Anatomy:	78.00
Physiology:	79.00
Biochemistry:	76.00
Pathology:	84.00
Microbiology:	86.00
Pharmacology:	83.00
Behavioral Science:	86.00
BASIC SCIENCE AVG.:	81.71

CLINICAL SCIENCE

Medicine:	83.00
Surgery:	82.00
Obstetrics:	80.00
Public Health:	86.00
Pediatrics:	84.00
Psychiatry:	90.00
CLINICAL SCIENCE AVG.:	84.16
CLINICAL COMPETENCE AVG.:	85.15
FLEX WEIGHTED AVG.:	84.00

RECEIVED
AUG 19 1986
DIVISION OF PROFESSIONAL LICENSING

* * * * * * * * * * * * * * * * *

DISCIPLINARY SEARCH: A search of the Federation's Disciplinary Data Bank reveals no reported disciplinary information on the above named physician.

THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE
CHAPEL HILL


FOWLER,S.A.

Name Sara Jane Arnold ~~Sara Arnold Fowler~~ Social Security Number 1 - DOH Licensee Socia...

Date of Birth 3/1/50 Place of Birth Vienna, Austria

GRADING SYSTEM: Honors, Pass, Fail

FIRST YEAR

Dates: 23 August 1976 - 25 May 1977

Courses

Cell Biology
General Pathology
Gross Anatomy
Histology
Immunology
Introduction to Medicine
Microbiology-Virology
Neurobiology

Summary Grade: _____ P

SECOND YEAR

Dates: 23 August 1977 - 18 April 1978

Courses

Biochemical Topics in Clinical Medicine
Cardiovascular-Respiratory System
Endocrine System
Gastrointestinal System
Hematology
Introduction to Psychiatry
Medicine and Society
Musculoskeletal System
Pathophysiology
Pharmacology
Physical Diagnosis
Radiobiology
Reproductive Biology
Skin and Connective Tissue
Urinary System

Summary Grade: _____ P

CLINICAL CLERKSHIPS	Dates
Surgery & Life Support Skills	15 May 1978 - 13 August 1978
Psychiatry	14 August 1978 - 24 September 1978
Pediatrics	25 September 1978 - 5 November 1978
Medicine	6 November 1978 - 11 February 1979
Obstetrics-Gynecology	26 March 1979 - 6 May 1979

Summary Grade: _____ P

ELECTIVES	Dates
Com Med 412 - Medical Ethics	Spring 1978
AHEC 402 - AI Medicine	4 June 1979 - 1 July 1979
FM 410 - Family Medicine Prcptship.	30 July 1979 - 26 August 1979
Externship - Tutorial Com.& Fam. Medicine	1 October 1979 - 25 November 1979
Radi 401 - General Radiology	26 November 1979 - 23 December 1979
Md/Pe 413 - Nephrology	4 February 1980 - 2 March 1980
Medi 411 - Infectious Diseases	31 March 1980 - 27 April 1980

Summary Grade: _____ P

M.D. Degree 11 May 1980 Date

JUL 22 1988
Date of Transcript

Connie M McManus
Registrar

THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE
CHAPEL HILL

FOWLER,S.A.

Name Sara Jane Arnold ~~Sara Arnold Fowler~~ Social Security Number [redacted]

Date of Birth 3/1/50 Place of Birth Vienna, Austria

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Physical Diagnosis
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Urinary System

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Md/Pe 413 - Nephrology	4 February 1980 - 2 March 1980
Medi 411 - Infectious Diseases	31 March 1980 - 27 April 1980

Summary Grade: _____ P

M.D. Degree 11 May 1980 (Date)

APR 30 1986

Date of Transcript

Registrar

STATE OF WASHINGTON
DEPARTMENT OF LICENSING

SARA JANE ARNOLD — March 1, ~~1986~~ SJA 1950
Name of applicant - Please print — Birthdate

I have applied for a license to practice medicine in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my postgraduate training program and return it directly to:

Division of Professional Licensing
Attention: Medical Section
P.O. Box 9649
Olympia, WA 98504

RECEIVED
JUN 2 0 1986
DIVISION OF PROFESSIONAL LICENSING

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Board of Medical Examiners.

Sara J. Arnold.
Signature of applicant

1. Is the applicant, or has the applicant been, engaged in postgraduate training in your program? Yes X No ___ If so, include dates, area of training (specialty). July 1, 1980 => June 30, 1983

2. Briefly evaluate his/her competence and conduct during the program. If performance evaluations were conducted, PLEASE INCLUDE COPIES. Fully competent in all evaluations, from all services upon which she rotated. Excellent resident

3. Has the program ever had cause to restrict, suspend or terminate, or ask for a voluntary resignation of his/her participation in the program? Yes ___ No X Please explain if yes ___

4. Is there anything in your files which could call into question his/her ability to safely practice medicine? Yes ___ No X Please explain if yes ___

PLEASE ATTACH ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION.

Name Robert E. Gwyther, MD
Title Director of Residency Education
Hospital North Carolina Memorial Hospital
Address Department of Family Medicine 209H
University of N. Carolina
Chapel Hill, N.C.
27514

Phone number (919) 966-3714

MED 657-034 Residency Ltr.
(R/4/83) wpc

STATE OF WASHINGTON
DEPARTMENT OF LICENSING

SARA JANE ARNOLD — Name of applicant - Please print

SJA
March 1 ~~1956~~ 1950 — Birthdate

I have applied for a license to practice medicine in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my postgraduate training program and return it directly to:

Division of Professional Licensing
Attention: Medical Section
P.O. Box 9649
Olympia, WA 98504

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Sara J. Arnold.
Signature of applicant

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2. Briefly evaluate his/her competence and conduct during the program. If performance evaluations were conducted, PLEASE INCLUDE COPIES. Fully competent in all evaluations, from all services upon which she rotated. Excellent resident

3. Has the program ever had cause to restrict, suspend or terminate, or ask for a voluntary resignation of his/her participation in the program? Yes ___ No X Please explain if yes ___

4. Is there anything in your files which could call into question his/her ability to safely practice medicine? Yes ___ No X Please explain if yes ___

PLEASE ATTACH ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION.

Name Robert E. Gaynor, MD
Title Director of Residency Educatio
Hospital North Carolina Memorial Hospital
Address Department of Family Medicine 269H
University of N. Carolina
Chapel Hill, N.C.
27514

Phone number (919) 966-3714

MED 657-034 Residency Ltr.
(R/4/83) wpc

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

The School of Medicine
Department of Family Medicine
919-966-3714

The University of North Carolina at Chapel Hill
Department of Family Medicine 269 H
Chapel Hill, N.C. 27514

July 31, 1986

Division of Professional Licensing
Attention: Medical Section
Post Office Box 9649
Olympia, WA 98504

RE: Sara Jane Arnold, M.D.

Dear Sirs:

I am writing at the request of Sara Jane Arnold, M.D., to confirm the dates of her Residency Program and give a summary of her performance in our Family Practice Residency Program. I have known Sara since 1980 when she became an intern in the Family Practice Program. At that time, I was Director of the Family Practice and Sara's "Team Advisor". I had extensive experience working with her throughout the three years of her Program.

Sara began her internship in July 1980 and finished the Program in June 1983. She consistently received above average to excellent ratings from her preceptors and faculty members. Her care of patients in the Family Practice Center was outstanding. Her fund of knowledge, sensitivity to patients, patient management, and attention to medical detail are all excellent.

I know Sara to be of the highest moral and ethical standards. She has an interest in occupational medicine and a great deal of expertise gained from her work with NIOSH. Her commitment to the improvement of the working environment of patients is genuine and positive.

Please do not hesitate to write or call me further regarding Dr. Arnold.

Sincerely,

Robert E. Gwyther, M.D.
Director of Residency Education

REG/ssl
Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

July 28, 1986

RECEIVED
AUG 01 1986
PROFESSIONAL LICENSING

Division of Professional Licensing
Medical Section
P.O. Box 9649
Olympia, Washington 98504

TO WHOM IT MAY CONCERN:

This is to advise that Sara J. Arnold, M.D., SURG 04, PHS #53401, SS 1 - DOH Licensee Social ..., was called to active duty in the U.S. Public Health Service (PHS) on July 4, 1983. Dr. Arnold was assigned to the Centers for Disease Control and was stationed in Cincinnati, Ohio. She inactivated from the PHS on July 3, 1985.

While stationed in Cincinnati, Dr. Arnold's supervisor was Blair Smith, and he reported that Dr. Arnold performed satisfactory.

Sincerely yours,

Louise M. Griggs

Louise M. Griggs
Chief, Commissioned Corps and
Fellow Program Section
Personnel Management Office

UNIVERSITY OF WASHINGTON
SEATTLE, WASHINGTON 98195

School of Medicine
Department of Family Medicine
Research Section, HQ-30

Robert Wood Johnson
Faculty Development
Fellowship Program

August 1, 1986

Division of Professional Licensing
Medical Licensure Section
P.O. Box 9649
Olympia WA 98504

To Whom It May Concern:

This letter verifies the current employment of Sara Jane Arnold, M.D., who has applied for a Washington State medical license. Dr. Arnold began the Robert Wood Johnson Family Medicine Faculty Development Fellowship Program on July 1, 1986. Admission to this two-year fellowship is competitive, and we are pleased to have Dr. Arnold in our program. Her letters of recommendation and record of previous training are excellent.

Please do not hesitate to call me if any additional information is necessary.

Sincerely yours,

Alfred O. Berg

Alfred O. Berg, M.D., M.P.H.
Director of the RWJ Academic Fellowship Program

AOB:tjc

Telephone: (206) 543-2461

STATE OF WASHINGTON
DEPARTMENT OF LICENSING

JUL 21 1986

SARA JANE ARNOLD — March 1, 1950
Name of applicant - Please print — Birthdate

I have applied for a license to practice medicine in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my licensure in your state and return it directly to:

Division of Professional Licensing
Attention: Medical Section
P.O. Box 9649
Olympia, WA 98504

RECEIVED
JUL 30 1986
DIVISION OF PROFESSIONAL LICENSING

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Board of Medical Examiners.

Sara J. Arnold
Signature of applicant

To assist the Board in evaluating the above physician's application, we would appreciate receiving the following information.

License No. 26716 Date of Issue 12/5/82

Is license current? Yes Yes No _____

License issued on basis of National Boards _____ Exam No

Reciprocity with _____ Other _____

Has a complaint regarding this physician ever been presented to your Board? Yes ____ No No

If yes: Is the investigation still in progress? Yes ____ No ____

If not, what was the Board's final action? Please attach information and pertinent documents.

Jean Babcock.
Signature

Unit Clerical Supervisor
Title

North Carolina Board Medical Examiners
State Board

MED-657-8 State Letter
(R/4/83) wpc

Application File_445850_pdf-r.pdf redacted on: 12/16/2014 11:48

Redaction Summary (4 redactions)

1 Privilege / Exemption reason used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (4 instances)

Page 1, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 12, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 13, 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