

Refunded 125.00

Physician Application Worksheet

Gibbons, Eileen

7-10-96

NAME 3-26-62 DATE OF BIRTH

DATE APPLICATION RECEIVED 10/23/96 DATE APPLICATION COMPLETED

100 Fee Photo Aids Personal Data Affidavit

Temporary Permit Fee Issue Date Expiration Date

Positive Data Questions Documentation Received

Chronology Completed Missing Dates to to to

Table with 4 columns: CASE NAME, SYNOPSIS, ORIGINAL COMPLAINT, DISPOSITION. Rows for Case 1, 2, 3, 4.

7/40 FDB 8/96 AMA ECFMG REINSTATEMENT

Medical School U.S. Canadian International Fifth Pathway

MEDICAL SCHOOL NAME U. WASH Transcript Translations YEAR OF DEGREE 1994

Examination Type National Board FLEX USMLE State Exam LMCC Scores Received

POSTGRADUATE TRAINING PROGRAM

Table with 4 columns for Postgraduate Training Program. Row 1: Providence 6/94-97

STATE LICENSURE

Table with 8 columns for State Licensure.

HOSPITAL PRIVILEGES

Table with 4 columns for Hospital Privileges.

STAFF DECISION

APPROVED DISAPPROVED

LICENSURE

SIGNATURE DATE 11-12-96

COMMENTS:

Valid # 001759

6124196

225.00 Check

Refunded 125.00

\$ 100.00 on full

AGENCY USE ONLY	
AGENCY NO.	LOCATION CODE
3030	

AGENCY NAME
 Department of Health
 Medical Quality Assurance Commission

CLAIMANT
 Gibbons, Eileen
 550 16th Ave Suite 100
 Seattle, WA 98102

DATE	DESCRIPTION	AMOUNT	FOR AGENCY USE
7/18/96	Overpayment of renewal	125 ⁰⁰	

VALIDATION INFO
 #1759 Date 06/24/96 \$225⁰⁰

~~MS~~ #7437 Exp Date N/A
 Going from ML to MD status

APPROVED BY: *Maria Glass* TELEPHONE NUMBER: 3-2999 DATE: 7/23/96 AGENCY APPROVAL: *Lisa Rigott* 7-24-96

AGENCY USE	TRANS CODE	FUND	PROGRAM	WORK CLASS	PROJECT	SUB PROJ	PROJ PHAS	MAJ GRP	MAJ SINCE	SUB SOURCE	AMOUNT
		02G						02	52	090000	

MEDICAL BOARD
bjel303
INDIVIDUAL NAME
LAST GIBBONS
FIRST EILEEN
MIDDLE

ASSESSMENT SYSTEMS, INC.
REAL SYSTEM
(JR, SR, III)

V 2.219
REFERENCE # ML20004654
SOC SEC NUM - -

11-07-96
10:15:53 AM

+-ADDITIONAL INFORMATION-----+
SEX M = MARRIED Y =

RESIDENCE INFORMATION
550 16TH AVENUE SUITE 100
SEATTLE, WA 98102

OTHER NAME
CORP. OFFICER
TRUST ACCOUNT =

BIRTH PLACE DALLAS, TEXAS
DATE 03-26-62

PHONE: () - COUNTY: 17
() - LGL ST: WA

SCHOOL CODE 054.04
CE UNITS 0.00 REQD BY 00-00-00

NOTES

-----+
CURRENT STATUS: A EXPIRATION DATE: 07-31-97 FIRST ISSUE DATE: 06-25-94
RENEWAL STATUS: Z LAST ACTIVE DATE: 00-00-00 LAST RENEWAL DATE: 06-25-96
COMPLAINTS O/C: 0/0 AUTHORITY: RE
-----+



Washington State Department of
Health
 Health Professional Quality Assurance Division
 PO Box 1099
 Olympia WA 98507-1099
 (360) 753-2844
 (360) 664-8689

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

All applications must be accompanied by applicable fee (fees are non-refundable).

All applicants carefully follow all instructions in general instructions.

It is the responsibility of the applicant to submit or request to have submitted, all required supporting documents.

Licensure Examination Taken (check one): National Board _____ State Examination LMCC (must have been obtained after 1969)
 FLEX Examination USMLE Examination

For Office Use Only		
Certificate No. <u>34303</u>	Issue Date <u>11/12/96</u>	Expiration Date _____
Please Type or Print Clearly		
Applicant's Name <u>GIBBONS</u> <u>EILEEN</u> <u>F.</u>		RECEIVED JUL 10 1996 MFS 5
<small>LAST FIRST MIDDLE INITIAL</small>		
Mailing Address <u>3304 South Morgan St.</u>		
City <u>Seattle</u> State <u>WA</u> Zip <u>98118</u> County <u>King</u>		
Telephone <u>(4) 721-0613</u> <u>(W) 320-2484</u>	Social Security Number _____	<small>1 - DOH Licensee Social Security Number - RCW 42.56... REQUESTED FOR IDENTIFICATION PURPOSES ONLY - ENTRY IS VOLUNTARY AND NOT REQUIRED FOR LICENSING APPROVAL</small>
<small>ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS</small>		
Home Address <u>3304 South Morgan St, Seattle, WA - 98118</u>		
<small>STREET CITY STATE ZIP</small>		
Sex (F or M) <u>F</u>	Birthdate <u>03-26-62</u>	Birthplace <u>Dallas, Texas</u>
<small>MONTH DAY YEAR CITY STATE COUNTY</small>		
Medical Speciality <u>Family Practice</u>		
Medical School <u>University of Washington</u>		Year of Graduation <u>1994</u>
<small>NAME</small>		
Have you previously applied for a Washington State License or limited license? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
List other name(s) that appear on documents or credentials <u>none</u>		

PERSONAL DATA

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 in 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 in 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? (Include driving under the influence and reckless driving.)

6. Have you ever been found in any civil, administrative, or criminal proceeding to have:

- a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances of legend drugs, violated any drug laws, 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 profession?

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.

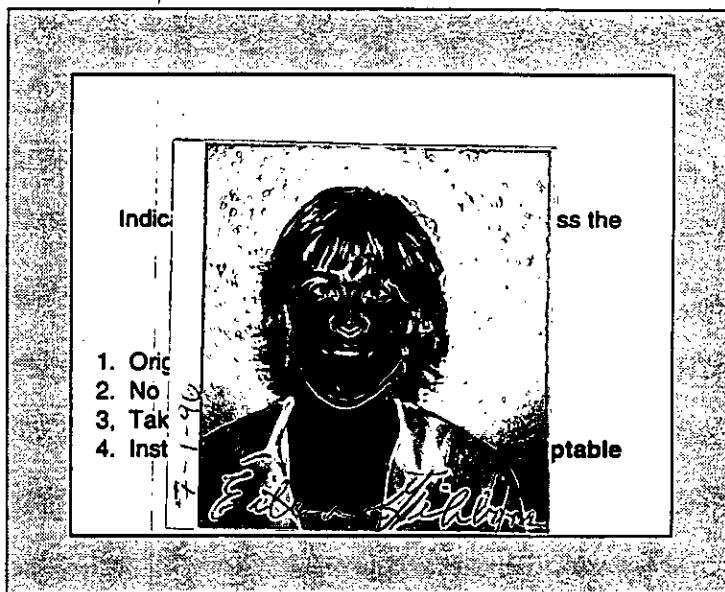
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked suspended, or restricted by a state, federal, or foreign authority or have you ever surrendered such credential to avoid or in connection with action by such authority?

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?

PERSONAL DATA QUESTIONS (Continued)

- | | | |
|---|------------------------------|--|
| 10. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 12. To the best of your knowledge, are you the subject of an investigation by any licensing board as of the date of this application? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

Identification	
HEIGHT 5' 7"	WEIGHT 140 lbs.
COLOR OF EYES green	COLOR OF HAIR brown



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		Diploma or Degree Obtained (Quote titles in original language and translate to English.)
		From (mo/yr)	To (mo/yr)	
Medical Education (List all Medical Schools Attended)				
University of Washington	5	9-89	6-94	M.D.
Post-Graduate Training (List all Programs Attended)				
Providence (medalia) Family Practice Residency	3	6-94	6-97	(upon completion of this last year 96-97 will have M.P.)

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 inch sheets if necessary.)

Nature of Experience or Practice	Dates of Experience	
	From (mo/yr)	To (mo/yr)
medalia Family Practice Clinic (Residency)	6-94	6-97

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 inch 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)	Ending (mo/yr)

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		Status of License Active or Inactive	Any Limitations on License
			Examination (Date Passed)	Endorsement		
none						

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

Name and Location of Medical School	Name and Location of Hospital	Dates Attended	
		Beginning (mo/yr)	Ending (mo/yr)
none			

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)

Eileen Gibbons
 APPLICANT'S SIGNATURE

6-30-96
 DATE

APPLICANT'S ATTESTATION

I, Eileen Gibbons, 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.

APPLICANT'S SIGNATURE
Eileen Gibbons

DATE
6-30-96

UNIVERSITY OF WASHINGTON OFFICE OF THE REGISTRAR

ACADEMIC TRANSCRIPT

UNIVERSITY OF WASHINGTON
 STUDENT NAME: GIBBONS, EILEENUF
 HIGH SCHOOL: IRELAND
 DATE PRINTED: 07/11/94
 PAGE: 1
 CONTROL: 521
 WASHINGTON RESIDENCY: RESIDENT
 CURRENT STATUS: STUDENT
 STUDENT DOES NOT AUTHORIZE RELEASE OF DIRECTORY INFORMATION

HEALTH GRAD: 12/15/80
 FEMALE
 RECUIT: 1983

ANY ALTERATION OR MODIFICATION OF THIS RECORD OR ANY COPY THEREOF MAY CONSTITUTE A FELONY
 UNIVERSITY OF WASHINGTON DEGREES EARNED:
 BACHELOR OF SCIENCE (ZOOLOGY)
 AUTUMN 1988 (12/15/88)
 UW 126 0 TRANSFER 92 5 EXTENSION 0 0 GPA 3.05
 DOCTOR OF MEDICINE
 SPRING 1994 (06/10/94)
 83 5 TRANSFER 0 0 EXTENSION 0 0 GPA 0.00
 SUMMARY OF TRANSFER CREDIT:
 NORTH SEATTLE C-C 5.0
 SEATTLE UNIV WA 5.0
 COMBINED 2 & /OR 4 YR COLLEGES 82.5
 GONZAGA U (WA) C-NOTRE DAME (CA) 0.0
 TRANSFER CREDIT ACCEPTED 0.0
 COMMENT:
 COUNT QSCI 38.1 AS PROF REC
 AUTUMN 1982 BIOL 2
 CHEM 231 ORGANIC CHEMISTRY 3.0 2.3
 CHEM 241 ORGANIC CHEM LAB 3.0 2.9
 MATH 124 CALC WITH ANALYT GEOM 5.0 2.8
 OCEAN 110 LECTURES IN OCEAN 1.0 3.8
 QTR ATTEMPTED 12.0 EARNED 12.0 GPA 2.78
 WINTER 1983 ZOO 3
 BIO 310 INDEP STUDY BIOL 3.0 CR
 CHEM 235 ORGANIC CHEMISTRY 3.0 2.2
 GEOG 100 INTRO TO GEOGRAPHY 5.0 3.9
 MUSIC 331 HISTORY OF JAZZ 3.0 2.8
 PSYCH 499 UNDERGRAD RESEARCH 3.0 4.0
 OCEAN 111 LECTURES IN OCEAN 1.0 3.8
 QTR ATTEMPTED 18.0 EARNED 18.0 GPA 3.35
 SPRING 1983 ZOO 3
 CHEM 236 ORGANIC CHEMISTRY 3.0 1.8
 CHEM 242 ORGANIC CHEM LAB 3.0 1.8
 CLAS 205 BIOSCIENTIFIC VOCAB 3.0 CR
 PSYCH 499 UNDERGRAD RESEARCH 3.0 4.0
 ZOO 301 INTRODUCTRY PHYSIO 4.0 1.8
 OCEAN 112 LECTURES IN OCEAN 1.0 3.3
 QTR ATTEMPTED 17.0 EARNED 17.0 GPA 2.38
 AUTUMN 1983 ZOO 3
 GEOL 1011 INTRO TO GEOL SCI 5.0 3.6
 PHYS 114 GENERAL PHYSICS 4.0 2.4
 PHYS 117 GENERAL PHYSICS LAB 1.0 CR
 ZOO 453 CMPR ANAT CHORDTS 5.0 3.0
 QTR ATTEMPTED 15.0 EARNED 15.0 GPA 3.04

COURSE	TITLE	CREDITS	GRADE
WINTER 1984			
MATH 125	CALC WITH ANALYT GEOM	5.0	*W
PHYS 115	GENERAL PHYSICS	4.0	2.2
PHYS 118	GENERAL PHYSICS LAB	1.0	CR
SOC 271	INTRO DEVIANCE	5.0	3.8
ZOO 454	CMPR ANAT CHORDTS	5.0	3.7
QTR ATTEMPTED 15.0 EARNED 15.0		GPA	3.31
SPRING 1984			
BOT 445	MARINE BOTANY	8.0	3.0
ZOO 430	MARINE ZOOLOGY	8.0	3.1
QTR ATTEMPTED 16.0 EARNED 16.0		GPA	3.05
AUTUMN 1984			
WITHDREW 10/04/84			
AUTUMN 1985			
BIOC 440	MOLECULAR BIOLOGY	3.0	W
QTR ATTEMPTED 3.0 EARNED 0.0		GPA	0.00
WITHDREW 12/09/85			
AUTUMN 1987			
BIOC 440	MOLECULAR BIOLOGY	3.0	2.7
QTR ATTEMPTED 3.0 EARNED 3.0		GPA	2.70
WINTER 1988			
BIOC 441	MOLECULAR BIOLOGY	4.0	W
QTR ATTEMPTED 4.0 EARNED 0.0		GPA	0.00
WITHDREW 03/11/88			
SUMMER 1988			
GENET 360	INTRO GENET	5.0	3.0
Q SCI 381	INTRO PROBABIL&STAT	5.0	2.5
ZOO 403	COMP VERT HISTOLOGY	5.0	3.5
QTR ATTEMPTED 15.0 EARNED 15.0		GPA	3.00
AUTUMN 1988			
BIOEN 299	INTRO TO BIOENGR	1.0	CR
MICRO 441	IMM MED BACT & VIR	3.0	3.1
NUTR 421	HUMAN NUTRITION	5.0	3.5
UCONJ 440	BIOLOG ASPECT AGING	3.0	4.0
ZOO 438	COMP ENDOCRINOLOGY	3.0	3.5
QTR ATTEMPTED 15.0 EARNED 15.0		GPA	3.52
SCHOLARSHIP STATUS HIGH			
DEGREE EARNED 12/15/88			
BACHELOR OF SCIENCE (ZOOLOGY)			
UW 126 0 TRANSFER 92 5 EXTENSION 0 0 GPA 3.05			

THE WORD "COPY" APPEARS WHEN PHOTOCOPIED

A BLACK AND WHITE DOCUMENT IS NOT OFFICIAL

RECIPIENT: UNIVERSITY OF WASHINGTON
 DEPT OF HEALTH
 1300 SE QUINCE ST BOX 47866
 OLYMPIA WA 98504
 In accordance with the Family Educational Rights and Privacy Act of 1974, information from this transcript may not be released to a third party without written consent of the student.

THIS IS AN OFFICIAL TRANSCRIPT ONLY IF SIGNED BY THE REGISTRAR AND EMBOSSED WITH THE SEAL OF THE UNIVERSITY OF WASHINGTON.
 IT MAY NOT BE RELEASED TO ANOTHER PARTY WITHOUT CONSENT OF THE STUDENT.
[Signature]
 Associate Registrar



EXPLANATORY NOTES

AUTHENTICATION OF THIS TRANSCRIPT:

A transcript is official when it bears the facsimile signature of the Registrar, the University of Washington Seal, and the production date. The background of this transcript is purple and the Registrar's signature is black. Further authentication can be obtained by calling the UW Transcript Office at (206) 543-5759. If photocopied, the word COPY will appear in the background. Alterations to the transcript will result in brown stains and/or white areas.

ACADEMIC CALENDAR:

The academic year is comprised of three quarters - autumn, winter, spring - each lasting approximately eleven weeks. There is also a summer quarter.

NUMERIC GRADE POINT EQUIVALENTS:

4.0-3.9 (A); 3.8-3.5 (A-); 3.4-3.2 (B+); 3.1-2.9 (B); 2.8-2.5 (B-); 2.4-2.2 (C+); 2.1-1.9 (C); 1.8-1.5 (C-); 1.4-1.2 (D+); 1.1-0.9 (D); 0.8-0.7 (D-); 0.0 (E); S (for undergraduates, 2.0 and above but prior to Autumn 1985 1.7 and above); S (for graduate students, 2.7 and above); NS (for undergraduates a grade less than 2.0 but prior to Autumn 1985 a grade less than 1.7); NS (for graduate students a grade less than 2.7).

SCHOOL OF LAW:

Letter grades: DS (Distinguished); H (Honors); P (Pass); LP (Low Pass); CR (Credit); NC (No Credit); I (Incomplete); N (satisfactory without grade); W (Withdrawal); HW (Hardship Withdrawal). Prior to Autumn 1990, numeric grades-credit awarded for grades 4.0 through 2.3; letter grades- CR, NC, I, N, *W, W and HW.

SCHOOL OF MEDICINE:

Letter grades: H (Honors), S, NS, CR, NC, I, N.

SCHOOL OF DENTISTRY:

Effective Autumn 1992: Numeric grades: 4.0 to 0.7 (a grade of 0.0 will be assigned to any grade below 0.7), H(honors), S, NS, CR, NC, I, N, W.

Prior to Autumn 1992: Numeric grades: 4.0 (honor), 3.7, 3.3, 3.0, 2.7, (good), 2.3, 2.0 (low pass), 0.0 (failure). Prior to Spring 1981, letter grades: A (4.0), B (3.0), C (2.0), E (failure), EW (failure withdrawal), CR, NC, I, N, W.

EXPLANATION OF GRADE SYMBOLS:

Numeric grades: 4.0, 3.9, decreasing by 1/10 to 0.7. The lowest grade is 0.0 which is a failing grade. The highest grade is 4.0.

Letter grades: I (Incomplete); N (satisfactory without grade); S (passing grade for courses taken on a satisfactory/not-satisfactory basis); NS (not satisfactory grade for courses taken on a satisfactory/not satisfactory basis); NC (credit not awarded in a course offered on a credit/no credit basis only); W (official complete withdrawal from the University, or course drop); beginning Autumn 1990 for undergraduates only, W accompanied by a number of 3 through 7 (designates course dropped week 3 through week 7 of all quarters except summer quarter); *W (prior to Autumn 1990, a peremptory drop made during the fifth through tenth week of the quarter); HW (Hardship Withdrawal); X (no grade submitted by instructor). Course titles preceded by the letter "H" designate honors courses; "W" are

writing courses; and, "B" are writing and honors courses.

SPECIAL SYMBOLS:

A grade followed by an I indicates an incomplete was initially awarded but a final grade has been received. Prior to Winter 1983, /R indicates course was repeated and only the last grade will count in grade point average. Beginning Winter 1983, /DR for a repeated course indicates both grades will count in the grade point average but credit will be allowed only once, /R for a graduate student indicates the student repeated a course not eligible to be repeated for grade or credit, and X/R is used for an undergraduate indicating the student repeated a course not eligible to be repeated for grade or credit. Beginning Autumn 1987, /R for undergraduates designates a language course initially taken in high school and repeated but not allowed credit and not included in the grade point average.

LOWEST PASSING GRADE:

Undergraduates, 0.7; Graduate students, 1.7.

EXPLANATION OF GRADE SYMBOLS USED PRIOR TO SUMMER QUARTER 1976:

A (honor); B (good); C (medium); D (poor-low pass); E (fail or unofficial withdrawal); EW (failing work at time of official withdrawal after the first fifteen calendar days of the quarter); PW (passing work at time of withdrawal after the first fifteen calendar days of the quarter); S (passing grade for courses 500 and above and for undergraduate courses taken on a satisfactory/not-satisfactory basis); CR (courses offered or taken on a credit/no credit basis where credit is awarded); NC (courses offered or taken on a credit/no credit basis where credit is not awarded).

COURSE LEVEL:

Lower division, 100-299; upper division, 300-499; graduate 500 and above.

TRANSCRIPTS:

Most student records were converted to a new transcript system in Winter Quarter 1983. You may receive two types of transcripts. The new transcripts are vertically printed and courses and grades supersede the horizontally printed record.

ACCREDITATION:

The University of Washington is accredited by the Northwest Association of Schools and Colleges.

This educational record is subject to the Family Educational Rights and Privacy Act of 1974, as amended. It is furnished for official use only and may not be released to or accessed by outside agencies or third parties without the written consent of the student concerned.

UoW 1592 (Rev. 1/94)

TO TEST FOR AUTHENTICITY: The face of this document has a purple background and the name of the institution appears in small print. Apply fresh liquid bleach to the sample background printed below. If authentic, the paper will turn brown.

UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON TRANSCRIPT • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON TRANSCRIPT
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WASHINGTON TRANSCRIPT • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON TRANSCRIPT • UNIVERSITY OF WASHINGTON • UNIVERSITY

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UNIVERSITY OF WASHINGTON

OFFICE OF THE REGISTRAR

ACADEMIC TRANSCRIPT

DATE PRINTED: 07/11/94
PAGE: 2

STUDENT NAME: T. GIBBONS EILEEN
 IRELAND
 BIRTHDATE: 03/26/62
 WASHINGTON RESIDENCY: RESIDENT
 SEX: FEMALE
 TRA: 1020
 CONTROL: 521
 CURRENT STATUS: COLLEGE/MAJOR
 UNIVERSITY OF WASHINGTON: UNIVERSITY OF WASHINGTON
 DEPARTMENT: MEDICINE/UNIV MEDICINE
 STUDENT DOESN'T AUTHORIZE RELEASE OF DIRECTORY INFORMATION

COURSE	TITLE	CREDITS	GRADE
FAMED 499	SUMMER 1991 UNDERGRAD RESEARCH	4.0	S
REHAB 654	P-2 YR CL ELCT PM&R	8.0	S
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
FAMED 501	AUTUMN 1991 P-INT' FAM MED PRCT	2.5	S
HUBIO 543	WINTER 1992 P-PRIN PHARM I	4.0	S
HUBIO 544	SPRING 1992 P-ENDOCRINE SYSTEM	2.5	S
HUBIO 546	FALL 1992 P-SYSTEMIC PATH	2.0	S
MHE 501	WINTER 1992 ALTERN SYST MEDICN	1.0	CR
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
HUBIO 501	WINTER 1992 P-HU BIO SPEC PROJ	12.0	H
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
HUBIO 501	SPRING 1992 P-HU BIO SPEC PROJ	10.0	S
HUBIO 530	FALL 1992 P-EPIDEMIOLOGY	2.0	S
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
OB GY 671	SUMMER 1992 P-OB GY CLERK ANCHD	12.0	S
PEDS 664	FALL 1992 P-PED GEN CLKSHIP	12.0	S
QTR	ATTEMPTED 24.0 EARNED 24.0	GPA: 0.00	
HUBIO 530	AUTUMN 1992 P-EPIDEMIOLOGY	2.0	X
HUBIO 531	WINTER 1992 P-HEAD NECK & ENT	5.0	S
HUBIO 532	SPRING 1992 P-NEUROV SYSTEM	6.0	S
HUBIO 534	FALL 1992 P-HIS INF DIS I-B	2.0	S
HUBIO 535	WINTER 1992 P-INTRO CLIN MED	4.0	S
QTR	ATTEMPTED 17.0 EARNED 17.0	GPA: 0.00	
HUBIO 540	AUTUMN 1990 P-CARDIOVASC SYS	5.5	S
HUBIO 541	WINTER 1990 P-RESPIRATORY SYS	4.0	S
HUBIO 542	SPRING 1990 P-INTRO CLIN MED	2.5	S
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
HUBIO 550	AUTUMN 1991 P-INTRO CLIN MED	3.5	S
HUBIO 551	WINTER 1991 P-GI SYSTEM	4.0	S
HUBIO 552	SPRING 1991 P-HEMATOLOGY	3.0	S
HUBIO 553	FALL 1991 P-MUSCULOSKELETAL	4.5	S
HUBIO 554	WINTER 1991 P-GENETICS	2.5	S
HUBIO 555	SPRING 1991 P-MED HLTH & SOC	3.5	S
QTR	ATTEMPTED 21.0 EARNED 21.0	GPA: 0.00	
HUBIO 560	AUTUMN 1992 P-INTRO CLIN MED	5.0	S
HUBIO 562	WINTER 1992 P-URINARY SYSTEM	4.0	S
HUBIO 563	SPRING 1992 P-SYST HU BEHAV II	3.0	S
HUBIO 564	FALL 1992 P-PRINDF PHARM II	3.0	S
HUBIO 565	WINTER 1992 P-REPRODUCTION	3.5	S
HUBIO 567	SPRING 1992 P-SKIN SYSTEM	2.0	S
QTR	ATTEMPTED 20.5 EARNED 20.5	GPA: 0.00	

COURSE	TITLE	CREDITS	GRADE
FAMED 499	SUMMER 1991 UNDERGRAD RESEARCH	4.0	S
REHAB 654	P-2 YR CL ELCT PM&R	8.0	S
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
FAMED 501	AUTUMN 1991 P-INT' FAM MED PRCT	2.5	S
HUBIO 543	WINTER 1992 P-PRIN PHARM I	4.0	S
HUBIO 544	SPRING 1992 P-ENDOCRINE SYSTEM	2.5	S
HUBIO 546	FALL 1992 P-SYSTEMIC PATH	2.0	S
MHE 501	WINTER 1992 ALTERN SYST MEDICN	1.0	CR
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
HUBIO 501	WINTER 1992 P-HU BIO SPEC PROJ	12.0	H
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
HUBIO 501	SPRING 1992 P-HU BIO SPEC PROJ	10.0	S
HUBIO 530	FALL 1992 P-EPIDEMIOLOGY	2.0	S
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
OB GY 671	SUMMER 1992 P-OB GY CLERK ANCHD	12.0	S
PEDS 664	FALL 1992 P-PED GEN CLKSHIP	12.0	S
QTR	ATTEMPTED 24.0 EARNED 24.0	GPA: 0.00	
HUBIO 530	AUTUMN 1992 P-EPIDEMIOLOGY	2.0	X
HUBIO 531	WINTER 1992 P-HEAD NECK & ENT	5.0	S
HUBIO 532	SPRING 1992 P-NEUROV SYSTEM	6.0	S
HUBIO 534	FALL 1992 P-HIS INF DIS I-B	2.0	S
HUBIO 535	WINTER 1992 P-INTRO CLIN MED	4.0	S
QTR	ATTEMPTED 17.0 EARNED 17.0	GPA: 0.00	
HUBIO 540	AUTUMN 1990 P-CARDIOVASC SYS	5.5	S
HUBIO 541	WINTER 1990 P-RESPIRATORY SYS	4.0	S
HUBIO 542	SPRING 1990 P-INTRO CLIN MED	2.5	S
QTR	ATTEMPTED 12.0 EARNED 12.0	GPA: 0.00	
HUBIO 550	AUTUMN 1991 P-INTRO CLIN MED	3.5	S
HUBIO 551	WINTER 1991 P-GI SYSTEM	4.0	S
HUBIO 552	SPRING 1991 P-HEMATOLOGY	3.0	S
HUBIO 553	FALL 1991 P-MUSCULOSKELETAL	4.5	S
HUBIO 554	WINTER 1991 P-GENETICS	2.5	S
HUBIO 555	SPRING 1991 P-MED HLTH & SOC	3.5	S
QTR	ATTEMPTED 21.0 EARNED 21.0	GPA: 0.00	
HUBIO 560	AUTUMN 1992 P-INTRO CLIN MED	5.0	S
HUBIO 562	WINTER 1992 P-URINARY SYSTEM	4.0	S
HUBIO 563	SPRING 1992 P-SYST HU BEHAV II	3.0	S
HUBIO 564	FALL 1992 P-PRINDF PHARM II	3.0	S
HUBIO 565	WINTER 1992 P-REPRODUCTION	3.5	S
HUBIO 567	SPRING 1992 P-SKIN SYSTEM	2.0	S
QTR	ATTEMPTED 20.5 EARNED 20.5	GPA: 0.00	

CONTINUED ON PAGE 3

UNIVERSITY OF WASHINGTON
 DEPT OF HEALTH SERVICES
 DEPT OF MEDICAL EXAMINERS
 1300 SE QUINCY ST BOX 47866
 OLYMPIA, WA 98504
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Van Johnson Associate Registrar

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ACADEMIC CALENDAR:

The academic year is comprised of three quarters - autumn, winter, spring - each lasting approximately eleven weeks. There is also a summer quarter.

NUMERIC GRADE POINT EQUIVALENTS:

4.0-3.9 (A); 3.8-3.5 (A-); 3.4-3.2 (B+); 3.1-2.9 (B); 2.8-2.5 (B-); 2.4-2.2 (C+); 2.1-1.9 (C); 1.8-1.5 (C-); 1.4-1.2 (D+); 1.1-0.9 (D); 0.8-0.7 (D-); 0.0 (E); S (for undergraduates, 2.0 and above but prior to Autumn 1985 1.7 and above); S (for graduate students, 2.7 and above); NS (for undergraduates a grade less than 2.0 but prior to Autumn 1985 a grade less than 1.7); NS (for graduate students a grade less than 2.7).

SCHOOL OF LAW:

Letter grades: DS (Distinguished); H (Honors); P (Pass); LP (Low Pass); CR (Credit); NC (No Credit); I (Incomplete); N (satisfactory without grade); W (Withdrawal); HW (Hardship Withdrawal). Prior to Autumn 1990, numeric grades-credit awarded for grades 4.0 through 2.3; letter grades-CR, NC, I, N, *W, W and HW.

SCHOOL OF MEDICINE:

Letter grades: H (Honors), S, NS, CR, NC, I, N.

SCHOOL OF DENTISTRY:

Effective Autumn 1992: Numeric grades: 4.0 to 0.7 (a grade of 0.0 will be assigned to any grade below 0.7). H(honors), S, NS, CR, NC, I, N, W.

Prior to Autumn 1992: Numeric grades: 4.0 (honor), 3.7,3.3,3.0,2.7, (good), 2.3,2.0 (low pass), 0.0 (failure). Prior to Spring 1981, letter grades: A (4.0), B (3.0), C (2.0), E (failure), EW (failure withdrawal), CR, NC, I, N, W.

EXPLANATION OF GRADE SYMBOLS:

Numeric grades: 4.0, 3.9, decreasing by 1/10 to 0.7. The lowest grade is 0.0 which is a failing grade. The highest grade is 4.0.

Letter grades: I (Incomplete); N (satisfactory without grade); S (passing grade for courses taken on a satisfactory/not-satisfactory basis); NS (not satisfactory grade for courses taken on a satisfactory/not satisfactory basis); NC (credit not awarded in a course offered on a credit/no credit basis only); W (official complete withdrawal from the University, or course drop); beginning Autumn 1990 for undergraduates only, W accompanied by a number of 3 through 7 (designates course dropped week 3 through week 7 of all quarters except summer quarter); *W (prior to Autumn 1990, a peremptory drop made during the fifth through tenth week of the quarter); HW (Hardship Withdrawal); X (no grade submitted by instructor). Course titles preceded by the letter "H" designate honors courses; "W" are

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LOWEST PASSING GRADE:

Undergraduates, 0.7; Graduate students, 1.7.

EXPLANATION OF GRADE SYMBOLS USED PRIOR TO SUMMER QUARTER 1976:

A (honor); B (good); C (medium); D (poor-low pass); E (fail or unofficial withdrawal); EW (failing work at time of official withdrawal after the first fifteen calendar days of the quarter); PW (passing work at time of withdrawal after the first fifteen calendar days of the quarter); S (passing grade for courses 500 and above and for undergraduate courses taken on a satisfactory/not-satisfactory basis); CR (courses offered or taken on a credit/no credit basis where credit is awarded); NC (courses offered or taken on a credit/no credit basis where credit is not awarded).

COURSE LEVEL:

Lower division, 100-299; upper division, 300-499; graduate 500 and above.

TRANSCRIPTS:

Most student records were converted to a new transcript system in Winter Quarter 1983. You may receive two types of transcripts. The new transcripts are vertically printed and courses and grades supersede the horizontally printed record.

ACCREDITATION:

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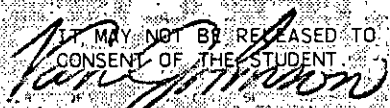
OFFICE OF THE REGISTRAR

NAME: GIBBONS, EILEEN HIGH SCHOOL: IRELAND HS GRAD: 12/15/80	DATE PRINTED: 07/11/94 PAGE: 3	STUDENT NUMBER: 220821 BIRTHDATE: 03/26/62 WASHINGTON RESIDENCY: RESIDENT SEX: FEMALE CONTROL: TRA1020 521
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COURSE TITLE	CREDITS GRADE
***** ANY ALTERATION OR MODIFICATION OF THIS RECORD FOR ANY COPY THEREOF MAY CONSTITUTE A FELONY ***** ***** AND/OR LEAD TO STUDENT DISCIPLINARY SANCTIONS ***** ***** WINTER 1994 MED 14 ***** ***** P-CL INFECTION 8.0 S ***** ***** P-OPHTHALMIC CLERKSHIP 4.0 S ***** ***** QTR ATTEMPTED 12.0 EARNED 12.0 GPA 0.00 ***** ***** SPRING 1994 MED 14 ***** ***** P-CL IN CLERKSHIPS 12.0 W ***** ***** QTR ATTEMPTED 12.0 EARNED 12.0 GPA 0.00 ***** ***** WITHDREW 04/26/94 ***** ***** DEGREE EARNED 06/10/94 ***** ***** DOCTOR OF MEDICINE ***** ***** UW 283.5 TRANSFER 0.0 EXTENSION 0.0 GPA 0.00 *****	
***** CUMULATIVE CREDIT SUMMARY ***** ***** UW CREDITS ATTEMPTED 283.5 UW CREDITS EARNED 283.5 ***** ***** UW GRADED ATTEMPTED 0.0 EXTENSION CREDITS 0.0 ***** ***** UW GRADED EARNED 0.0 TRANSFER CREDITS 0.0 ***** ***** UW GRADE POINTS 0.0 ***** ***** UW GRADE POINT AVG: 0.00 CREDITS EARNED 283.5 ***** ***** END OF RECORD *****	

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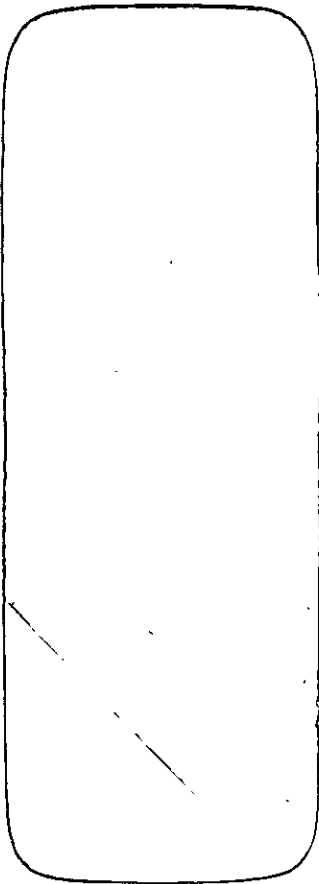
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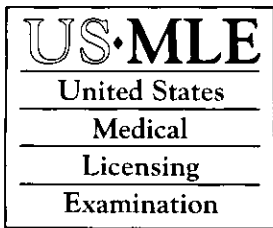
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Office of the Registrar, PD-10
1410 N.E. Campus Parkway, Room 260
Seattle, Washington 98195





UNITED STATES MEDICAL LICENSING EXAMINATION™

The Federation of State Medical Boards of the U.S., Inc.
 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855
 Telephone: (817) 571-2949

WA-1

STEP 3 SCORE REPORT

*** * * MEDICAL BOARD FILE COPY * * ***

Gibbons, Eileen Frances

USMLE ID: 4-003-208-8

**3304 S Morgan St
 Seattle, WA 98118**

Test Date: June 1995

The USMLE is a single examination program for all applicants for medical licensure in the United States; it replaces the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. **Step 3** is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 3 on the test date shown above.

PASS	This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.
-------------	---

187	This score is determined by your overall performance on the examination. The score scale is defined to have a mean of 200 and a standard deviation of 20 based on the projected performance of recent graduates from medical schools accredited by the Liaison Committee on Medical Education (LCME). Most examinees receive a score between 140 and 260. The standard error of measurement (SEM) [‡] for a USMLE three-digit scale is usually in the range of 4 to 5 points.
------------	--

78	This score is also determined by your overall performance on the examination. A score of 82 on this scale is equivalent to a score of 200 on the scale described above. A score of 75 on this scale represents the minimum pass score recommended by USMLE to pass Step 3 and is equivalent to the score printed below. The SEM [‡] for a USMLE two-digit scale is usually in the area of 1 point.
-----------	---

The three-digit score recommended to pass Step 3:	176
---	------------

[‡]Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The standard error of measurement (SEM) provides an estimate of the range within which your scores might be expected to vary by chance if you were tested repeatedly using similar tests.

TO: Post-Graduate Training Program Director

Sam Callison, M.D.
FACILITY NAME
550-16th Ave. Suite 100
ADDRESS
Seattle, WA 98122

RECEIVED
OCT 23 1996

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 shown below. Thank you for your attention to this matter.

Eileen Gibbons
APPLICANT (PRINT OR TYPE) 3-26-62
BIRTHDATE
Eileen Gibbons
SIGNATURE OF APPLICANT

1. Eileen Gibbons is or was engaged in post-graduate training in our program
from 6-25-94 to 6-30-97
in the field of Family Practice

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

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.

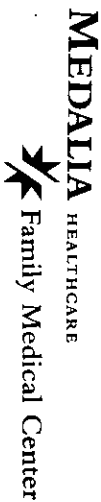
5. We would appreciate any further documentation you feel would assist in the evaluation process. Thank you.

Return to:
Medical Quality Assurance Commission
1300 SE Quince Street
P O Box 47866
Olympia, WA 98504-7866
206-664-8689 or 753-2844

(Seal)

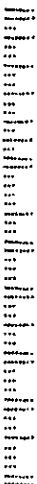
Signature *[Signature]*
Title Res. Med. Director
Hospital Providence Hospital
Address PLEASE TYPE OR PRINT 550-16th Ave
Seattle, WA 98122
Date 10-22-96

Medalia HealthCare LLC
Family Medical Center
550 16th Avenue, Suite 100
Seattle, WA 98122



Medical Quality Assurance Commission
1300 SE Quince St.
Box 417 866
Olympia, WA. 98504-7866

Providence and Franciscan Health Systems 98504-7866



TO: Post-Graduate Training Program Director

Sam Cullison
FACILITY NAME

ADDRESS

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 shown below. **All questions must be answered.**

Eileen Gibbons
APPLICANT (PRINT OR TYPE)

3-26-67
BIRTHDATE

Eileen Gibbons
SIGNATURE OF APPLICANT

RECEIVED
JUL 10 1996

1. Eileen Gibbons is or was engaged in post-graduate training in our program from 6-94 to 6- in the field of

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

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.

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1300 SE Quince Street
P O Box 47866
Olympia, WA 98504-7866
(360) 364-3689 or (360) 753-2944

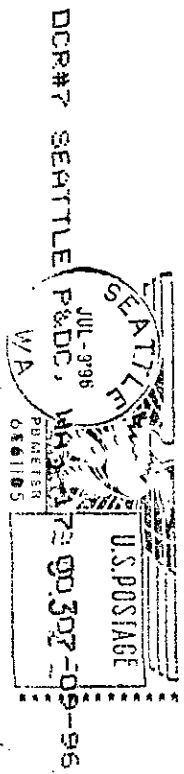
Signature [Signature]
Title Residency Director
Hospital Providence Hospital
Address 520 16th St 100
Seattle WA 98122
Date 7/13/96
Telephone 206 320 2233

(Seal)

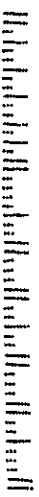
Medalia HealthCare LLC
Family Medical Center
550 16th Avenue, Suite 100
Seattle, WA 98122

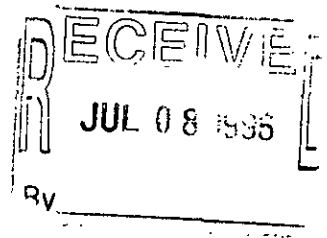
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Box 47866
Olympia, WA 98504 - 7866



Providence and Franciscan Health Systems



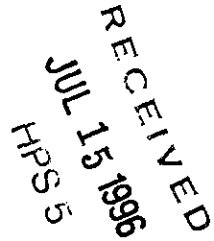


TO THE APPLICANT

Complete the identifying information below and submit to:

**Federation of State Medical Boards
400 Fuller Wiser Road
Euless, Texas 76039-3855**

Attention: Barbara Rains
Board Inquiry Specialist



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

Date:

Dear Ms. Rains:

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 Washington State Medical Quality Assurance Commission. Thank you for your assistance.

NAME: Eileen Gibbons

SSN:

MEDICAL SCHOOL OF GRADUATION: Univ. of Washington

YEAR OF GRADUATION: 1994

BIRTHDATE: 3-26-62

RESPONSE:

**WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN**

JUL 12 1996

James R. Winn, M.D.
**JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT**

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:

EILEEN F GIBBONS MD
3304 S MORGAN ST
SEATTLE WA 98118 USA

Phone: UNKNOWN
Birthdate: 03/26/1962
Birthplace: DALLAS TX USA

Physician's Major Professional Activity: RESIDENT

Self Designated Practice Specialties (SDPS):

Primary: FAMILY PRACTICE
Secondary: UNSPECIFIED

AMA membership: NOT A MEMBER

RECEIVED
AUG 12 1996
HPC

Following Data Provided by the Primary Sources

Medical School:

UNIV OF WA SCH OF MED, SEATTLE WA 98195

Year of Graduation: 1994

Current and/or Prior Medical Training or Fellowship:

Institution: PROVIDENCE-SEATTLE MED CTR
RESIDENT

State: WASHINGTON
(VERIFIED)

Specialty : FAMILY PRACTICE

07/01/1994 - 06/30/1997

Note: Additional information on physicians in graduate medical training is not solicited, nor is it received from the residency program directors. If you feel additional information may be available, contact the program director(s).

National Board Certification Year:

NONE REPORTED TO DATE

ECFMG Certification:

Number	Certificate Date	Status
--------	------------------	--------

NONE REPORTED TO DATE

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 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.

Board of Medical Examiners
Limited Physician Application Worksheet

Gibbons, Eileen
NAME
3-26-62
DATE OF BIRTH

12-12-94
DATE APPLICATION RECEIVED
DATE APPLICATION COMPLETED

Fee Photo Personal Data Aids Affidavit
 Residency Fellowship Teaching/Research Institutions City/County

Positive Data Questions _____ Documentation Received _____
Chronology Completed _____ Missing Dates 7/94 to 12/94 (present) to _____

MALPRACTICE CASE	SYNOPSIS	ORIGINAL COMPLAINT	DISPOSITION	
CASE 1 NAME:				<u>1219</u> FDB
CASE 2 NAME:				AMA
				ECFMG

Medical School U.S. Canadian International Fifth Pathway
MEDICAL SCHOOL NAME: Univ. of WA 714 Transcript _____ Translations YEAR OF DEGREE: 1994

Examination Type National Board FLEX USMLE State Exam LMCC Scores Received: _____

POSTGRADUATE TRAINING PROGRAM

STATE LICENSURE

--	--	--	--	--	--

HOSPITAL PRIVILEGES

EMPLOYMENT/PROGRAM VERIFICATION

<u>12-12</u>	<u>Providence Med. Ctr. (6-25-94)</u>

STAFF DECISION
 APPROVED
 DISAPPROVED

LICENSURE
Janice Weber 26-95
SIGNATURE DATE

COMMENTS:

ML4654

PROVIDENCE MEDICAL CARE CENTERS
P.O. BOX 34280
SEATTLE, WASHINGTON 98124-1280
A DIVISION OF PROVIDENCE MEDICAL CENTER



SISTERS OF
PROVIDENCE
HEALTH SYSTEM
Serving in the West since 1856

June 25, 1995

ML4654
Please
archive

State of Washington
Department of Licensing
Division of Professional Licensing
1300 S.E. Quince St.
P.O. Box 47866
Olympia, WA 98504-7866

To Whom It May Concern:

This is to certify that Eileen F. Gibbons, M.D. has successfully completed one year of postgraduate medical training in the Providence Family Practice Residency Program from 6/25/94 to 6/26/95. Providence Residency Program is accredited by the ACGME.

Sincerely,

Samuel W. Cullison, M.D.
Director

PROVIDENCE BALLARD: 783-5054
PROVIDENCE CROSSROADS: 643-8500
PROVIDENCE DOWNTOWN: 554-7700
PROVIDENCE FACTORIA: 641-4000
PROVIDENCE FAMILY MEDICAL CENTER: 320-2484

PROVIDENCE GREENLAKE: 522-2314
HEALTHCARE FOR WOMEN: 320-2766
PROVIDENCE ISSAQUAH: 391-8630
PROVIDENCE NORTHGATE: 524-5982
PROVIDENCE QUEEN ANNE: 283-1842

PROVIDENCE RAINIER: 722-8444
PROVIDENCE SEA-MED: 329-0200
PROVIDENCE UPTOWN: 320-4888
PROVIDENCE WEST SEATTLE: 932-6933
CONSOLIDATED BUSINESS OFFICE: (206) 320-2016

Approved
11/7/96
for Temp



Office of the Dean

Mailstop SC-64
A-300 Health Sciences Center
Seattle, WA 98195
Phone: (206) 543-1060
Fax: (206) 543-3639

June 8, 1994

State of Washington
Department of Health
Board of Medical Examiners
1300 S.E. Quince Street
P.O. Box 47866
Olympia, Washington 98504-7866

RECEIVED
JUN 14 1994
HEALTH PROFESSIONS SECTION 5

To Whom It May Concern:

This letter is to certify that Eileen Gibbons graduated on June 10, 1994 from the University of Washington School of Medicine with the degree of Doctor of Medicine after successful completion of all the requirements. This is also to certify that at least seventeen hours of AIDS education have been completed while in the medical school curriculum.

Sincerely,

A handwritten signature in cursive script that reads "Patricia Mallory".

Patricia Mallory
Registrar

PM/bhs



1300 SE Quince St.
Olympia, WA 98504
206-753-2999 or 753-2205

Board of Medical Examiners Residency Certification

This is to certify that Eileen Gibbons has been

appointed as a resident in Family Practice at
SERVICE

the Providence Family Medical Center hospital for the period

beginning June 25, 1994 . The individual responsible for this resident's patient care activities
MONTH DAY YEAR

will be 
(SIGNATURE) DIRECTOR OF PROGRAM

Kevin Murray, M.D., Acting Director

- Residents physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.055 and is serving a period of postgraduate clinical medical training sponsored by a college or university in this state or by a hospital accredited by this state. The term shall include individuals designated as intern or medical fellow.

(Hospital Seal)

PROVIDENCE MEDICAL CARE CENTERS
P.O. BOX 34280
SEATTLE, WASHINGTON 98124-1280
A DIVISION OF PROVIDENCE MEDICAL CENTER



SISTERS OF
PROVIDENCE
HEALTH SYSTEM
Serving in the West since 1856

FACSIMILE TRANSMISSION COVER SHEET

Date: 12/12/94

Fax Number: 206-586-4573

TO: Name: Carolyn Bradley
Department: Medical Licensing Phone# 206-753-8444
Company/Organization: State of Wash

FROM: Providence Family Medical Center, Seattle, Washington

Name: CAROL JOHANNSON
Department: FAMILY MEDICINE Phone# 320-2233

NUMBER OF PAGES (including cover): 2

Privileged & Confidential. The information contained in this faxed document is privileged or confidential and is intended solely for the use of the individual(s) named above. If you are not an intended recipient, you are hereby advised that any dissemination, re-distribution or copying of this communication is prohibited. If you have received this FAX in error, please immediately notify the sender by telephone and destroy the original facsimile. Health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interests in privacy, health care or other interests.

COMMENTS:

Please phone (206) 320-2233 if there are any transmission problems.



1300 SE Quince St.
 Olympia, WA 98504
 206-753-2999 or 753-2205

Board of Medical Examiners
Residency Certification

This is to certify that Eileen Gibbons has been

appointed as a resident* in Family Practice at
SERVICE

the Providence Family Medical Center hospital for the period

beginning June 25, 1994. The individual responsible for this resident's patient care activities
MONTH DAY YEAR

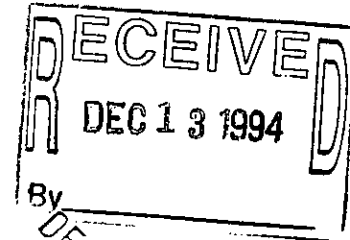
will be *Kevin Murray MD*
(SIGNATURE) DIRECTOR OF PROGRAM

Kevin Murray, M.D., Acting Director

- * Residents physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.055 and is serving a period of postgraduate clinical medical training sponsored by a college or university in this state or by a hospital accredited by this state. The term shall include individuals designated as intern or medical fellow.

(Hospital Seal)

Department of Health
Board of Medical Examiners
1300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504-7866



Date: 6/10/94

Dear Ms. Rains:

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 Washington State Medical Board. Thank you for your assistance.

NAME: Eileen Gibbons

SSN:

MEDICAL SCHOOL OF GRADUATION: Univ. of Washington

YEAR OF GRADUATION: 1994

BIRTHDATE: 3-26-62

RESPONSE:

MEDICAL BOARD
DEC 19 1994
RECEIVED

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

DEC 14 1994

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



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Medical Quality Assurance Commission

1300 SE Quince St, M.S. 7866, Olympia, WA 98504-7866 • (360) 753-2287

January 26, 1995

Eileen F. Gibbons, MD
550 - 16th Avenue
Suite 100
Seattle, WA 98102

Dear Dr. Gibbons:

This is to acknowledge receipt of your application to obtain licensure as a physician and surgeon in the state of Washington. According to our records the following items have not been received to complete your application:

Missing Chronology, 7/94-Present

A deficiency letter will be sent every four to six weeks until the application is considered complete. Depending on the complexity of the application file, the review process may take from five to ten working days. If your application contains negative information, it will require a review by a Commission Member and a presentation at the following Commission meeting for final disposition.

If you have any questions, please feel free to contact me at (206) 753-2844.

Sincerely,

Carolynn Bradley,
Licensing Representative



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 SE Quince St • P.O. Box 47866 • Olympia, WA 98504-7866

August 6, 1996

Eileen Gibbons, MD
3304 South Morgan St
Seattle, WA 98118

Dear Dr Gibbons

This is to acknowledge receipt of your application to obtain licensure as a physician and surgeon in the state of Washington. According to our records the following items have not been received to complete your application:

**AMERICAN MEDICAL ASSOCIATION PROFILE
POST GRADUATE TRAINING
PROVIDENCE 6/94-97**

A deficiency letter will be sent every four to six weeks until the application is considered complete. Depending on the complexity of the application file, the review process may take from five to ten working days. If your application contains negative information, it will be reviewed at the next Commission meeting for final disposition.

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

October 21, 1996

Eileen Gibbons, MD
3304 South Morgan St
Seattle, WA 98118


Dear Dr Gibbons

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 documents:

**Post Graduate Training
Providence 6/94-97**

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) 753-2844.

Sincerely,

Betty Elliott
Program Representative

APPLICATION FOR
**LIMITED LICENSE
TO PRACTICE MEDICINE**
Applicable for MD's Only

MEDICAL UNIT
DEC 12 1994
RECEIVED

~~ML2000416A~~

FOR OFFICE USE ONLY
CERTIFICATE NO. ML2000416A ISSUE DATE 10-25-94 EXPIRATION DATE 7-31-95

~~ML5923~~

ISS 2-6-95

Limited license application is made in conjunction with employment in: (check one)

- Institutional
 Fellowship - 2 year limit
 Internship-Residency
 County-City Health Department
 Teaching-Research - 2 year limit

PLEASE TYPE OR PRINT CLEARLY

Applicant's Name GIBBONS EILEEN F.
LAST FIRST MIDDLE INITIAL

Name of Institution/Health Dept/Medical School/Hospital Providence medical center

Address 650 - 16th Ave. Suite 100

City Seattle State WA ZIP 98102

Telephone No. (Home) 325-7577 721-0613 Social Security Number
(Work) 320-2484
ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS

REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND NOT REQUIRED FOR LICENSING APPROVAL.

Sex (F or M) F Birthdate 3 - 26 - 62
MONTH DAY YEAR

Birthplace Dallas, Texas, U.S.A.
CITY STATE COUNTRY

Medical specialty Family Practice

Medical School Attended Univ. of Washington, U.S.A. Year of Graduation 1994
NAME/COUNTRY

List other name(s) that may appear on documents or credentials NA

Have you previously applied for a Washington State Medical License or limited license? Yes No

Follow carefully all instructions in general instructions - all applicants. It is the responsibility of the applicant to submit or request to have submitted, all required supporting documents.

LICENSES IN OTHER STATES/COUNTRIES

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

STATE, COUNTRY OR PROVINCE	DATE LICENSE ISSUED	NUMBER	BASIS OF LICENSURE		STATUS OF LICENSE ACTIVE/ INACTIVE)	ANY LIMITATIONS ON LICENSE
			EXAMINATION (DATE PASSED)	ENDORSEMENT		
(none)						

AID'S 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 if requested. (WAC 246-917-060)

Eileen Gibbons

SIGNATURE

6/10/94

DATE

APPLICANT'S ATTESTATION

EILEEN GIBBONS

(PRINT OR TYPE FULL NAME OF APPLICANT)

I, EILEEN GIBBONS, state 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 this 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 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.

Eileen Gibbons

SIGNATURE OF APPLICANT

6/10/94

DATE

IDENTIFICATION

HEIGHT 5'7"	WEIGHT 140#
COLOR OF EYES Blue	COLOR OF HAIR Brown



- 1.
- 2.
- 3.
- 4.
- 5.

table

EDUCATION AND EXPERIENCE

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

(Attach additional 8 1/2 x 11 sheet 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	ATTENDANCE		DIPLOMA OR DEGREE OBTAINED QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH
		ENTRANCE	LEAVING	
		DATE MO./YR.	DATE MO./YR.	
Medical Education (List all Medical Schools Attended)				
Univ. of Washington	5	9/89	6/94	M.D.
Post-Graduate Training (List all programs attended)				

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 sheet if necessary)

INDICATE NATURE OF EXPERIENCE OR PRACTICE	INCLUSIVE DATES OF EXPERIENCE	
	BEGINNING MO./YR.	ENDING MO./YR.
(None)		

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

(Attach additional 8 1/2 x 11 sheet if necessary)

(FOR LOCUM TENENS, ENTER ONLY THOSE OF A 30 DAY OR LONGER DURATION. SEE INSTRUCTIONS REGARDING REPORTS AND VERIFICATION.)	BEGINNING DATE	ENDING DATE
(none)		

PERSONAL DATA

Yes No

- 1. Have you ever had a license to practice medicine suspended, revoked, restricted or denied or voluntarily surrendered a physicians license in any state, federal or foreign jurisdiction? Yes No
- 2. Have you ever had hospital privileges, or medical society membership revoked, suspended, restricted or denied on grounds of unprofessional conduct, incompetence, negligence, or unsafe practices? Yes No
- 3. Have you ever been convicted of any gross misdemeanor or felony relating to the practice of medicine? Yes No
- 4. Have you ever been the recipient of any disciplinary action, including reprimand or have you ever entered a stipulated agreement or agreed to discontinue an act alleged as a violation of law or an unsafe practice? Yes No
- 5. Have you ever been notified that any information pertaining to you been submitted to the National Data Bank? Yes No
- 6. Have you ever been denied a DEA registration number or been issued a restricted DEA registration or voluntarily surrendered a DEA registration? Yes No
- 7. To the best of your knowledge, are you the subject of an investigation by any licensing board as of the date of this application? Yes No
- 8. Have you ever agreed to restrict your practice in lieu of or to avoid formal action? Yes No

If response to 1-8 is affirmative, attach certified copies of orders, stipulations, agreements, charges, judgements sentences, findings and nature of decisions. If on parole or probation, include a letter from the supervising officer indicating progress.

- 9. Have you ever been found guilty of the violation of any drug law, or prescribing controlled substances for yourself or been found guilty of a traffic citation involving drug or alcohol? Yes No
- 10. Have you ever been involved in the possession, use, prescription for use, or diversion of controlled substances or legend drugs in any other way than for legitimate or therapeutic purposes? Yes No
- 11. Have you ever submitted or been required to submit for treatment for alcohol dependency? Yes No

If response to 9 through 11 is affirmative, attach copies of charges, sentences, orders, stipulation and/or dispositions. Also include letters from the treating professional and/or institution stating details of condition or addiction, treatment and prognosis.

- 12. Have you ever received treatment for a mental illness? Yes No
- 13. Have you ever been released from or restricted in a medical program because of a mental condition or illness? Yes No
- 14. Are you currently afflicted with a mental or physical condition which impairs or restricts your ability to practice with reasonable skill and safety? Yes No

If response to 12 through 14 is affirmative, attach copies of letters from treating professional, program and/or institutions describing diagnosis, treatment and prognosis. This information is treated as confidential and exempt from public disclosure unless formal disciplinary action is taken against your application on the basis of a mental or physical condition impairing your ability to practice with reasonable skill and safety.

- 15. Have you been named in any malpractice suits alleging your incompetence or negligence in the practice of medicine? Yes No
If yes, 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, indicate the status.

**Failure To Give Complete And True Information Constitutes Cause For Denial
Of Your Application For Licensure
RCW 18.130.180(2)**

000176 12/20/94 22500

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

Limited Physician

EILEEN GIBBONS

NAME (Please Print)

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

DATE

6-16-94

<input checked="" type="checkbox"/>	Check	<input type="checkbox"/>	Money Order
\$	<u>225.00</u>		

*

Please note amount enclosed, and return with your application. \$ 225.00

First
* Free until 6-day.

JA 0252140000 00336

Redaction Summary (6 redactions)

1 Privilege / Exemption reason used:

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



- Page 6, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 10, 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 14, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 22, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 35, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance