Date: 7/26/2006

To: Customer Service Center

From: Betty Elliott, 4785
Medical, Section 5

Refund to be processed for:

Andrea Lucas MD
Group Health Cooperative
125 16th Ave E CSB 160
Seattle WA 98112

Reason for the refund: Overpayment for limited going to full license

Paid $325.00 instead of $125.00
Refund $200.00

(Please include explanation for refund. Here is a renewal example: *"Renewal received 2/11/04 #0073 ($25.00 renewal fee). Second renewal fee received 2/20/2004 #1996 ($25.00 renewal fee). Refund $25.00."*)

Cash slip is:

0284 06/27/2006 $325.00

Attachments

(Attachments must include a copy of application, a copy of the front and back of deposit slip with cash number written on the back of the deposit slip, three ASI screens – 1) main ASI demographic screen, 2) the license update screen (F4 + F4), and 3) the deposit code transaction screen which will show how the cash number was applied .)

telnet (GothomCity2)

```
                      AAAAAA     SSSSSS    IIIIIIIIII
                     AAAAAAA    SSS  SSS   IIIIIIIIII
                    AAAAAAAA   SSS    SSS      III
MEDICAL BOARD              ASSESSMENT SYSTEMS, INC.                  07-26-06
bje1303                          REAL SYSTEM          V2.5.74        08:46:54 AM

+-----------------------------------------------------+
|                                                     |
|       CASH NUMBER:  061780284                       |
|                                                     |
|      RECEIPT DATE: 06-27-2006                       |  STATUS      CASH NUMBER
|                                                     |8  A
|  REFERENCE NUMBER: MD00046899                       |
|         TYPE CODE:                              =   |
|                                                     |
|          FULL NAME: ANDREA P. LUCAS                 |
|        DESCRIPTION:                                 |            LAST NAME
|                                                     |
|        FEE CODE       AMOUNT                        |
|                                                     |
|     1  APP-TX           100.00                      |
|     2  SAMP              25.00                      |
|     3  REFUND           200.00                      |
|     4                     0.00                      |
|                         325.00                      |
+-----------------------------------------------------+
1 ABORT   2ACCEPT   3         4         5         6         7         8 NOT REQ
```

CREDENTIALING UNIT
TRANSMITTAL SHEET

☐ FULL APPLICATION ☐ TEMPORARY PERMIT ☐ LIMITED APPLICATION

FILE COMPLETED _____ (DATE)	SUBMITTED FOR REVIEW _____ (DATE)	
FILE APPROVED ☐ (SEE WORKSHEET FOR SIGNATURE)	FILE INCOMPLETE ☐	FILE RETURNED _____

ITEMS IDENTIFIED AS INCOMPLETE/INCORRECT:

	ITEM RECEIVED
•	_____
•	_____
•	_____
•	_____

FILE RE-SUBMITTED FOR REVIEW _____ EXCEL REPORT UPDATED ☐
(LAST DOCUMENT DATE)

FILE APPROVED ☐ (SEE WORKSHEET FOR SIGNATURE)	FILE INCOMPLETE ☐	FILE RETURNED _____

ITEMS IDENTIFIED AS INCOMPLETE/INCORRECT:

	ITEM RECEIVED
•	_____
•	_____

FILE RE-SUBMITTED FOR REVIEW _____ EXCEL REPORT UPDATED ☐
(LAST DOCUMENT DATE)

FILE APPROVED ☐ (SEE WORKSHEET FOR SIGNATURE)	FILE INCOMPLETE ☐	FILE RETURNED _____

ADDITIONAL COMMENTS:

telnet (GothomCity)

```
                      AAAAAA     SSSSSS    IIIIIIIIII
                     AAAAAAA    SSS  SSS   IIIIIIIIII
                    AAAAAAAA   SSS    SSS      III
MEDICAL BOARD              ASSESSMENT SYSTEMS, INC.                  07-11-06
bje1303                          REAL SYSTEM          V2.5.74        02:40:44 PM
INDIVIDUAL NAME                   (JR,SR,III)       REFERENCE # ML20008178
   LAST LUCAS                                       SOC SEC NUM
  FIRST ANDREA                          +-ADDITIONAL INFORMATION----------------+
 MIDDLE P                               |          SEX F =      MARRIED Y =      |
                                        |                                        |
RESIDENCE INFORMATION                   |   OTHER NAME                           |
GROUP HEALTH COOPERATIVE                |CORP. OFFICER                         = |
125 16TH AVE EAST CSB 160               |TRUST ACCOUNT                           |
SEATTLE WA 98112                        |                                        |
                                        |  BIRTH PLACE CHULA VISTA CA            |
                                        |        DATE 01-10-1974                 |
PHONE: (   )     -      COUNTY:   17    |                                        |
       (   )     -      LGL ST:         |SCHOOL CODE 039010                      |
                                        |   CE UNITS    0.00 REQD BY   -  -      |
NOTES                                   +----------------------------------------+

+-------------------------------------------------------------------------------+
|CURRENT STATUS: A    EXPIRATION DATE: 06-30-2006  FIRST ISSUE DATE: 05-25-2005|
|RENEWAL STATUS: M   LAST ACTIVE DATE:   -  -     LAST RENEWAL DATE: 05-25-2005|
|COMPLAINTS O/C:  0/ 0      AUTHORITY:                                          |
+-------------------------------------------------------------------------------+
1GO BACK  2NAM&ADDR 3EDUCATE  4LIC FUNC 5INVESTG  6         7OTHR DAT 8EXTD NOT
```

Medical Quality Assurance Commission
Physician Application Worksheet

Name LUCAS ANDREA Date of Birth 01/10/1974

Date Received 7/7/06 Cash Number _____ Candidate Number _____

x	WSP Check	x	Fee	x	Photo	x	Data1-13	x	AIDS	x	Attest	x	SSN	x	Garfield Search

Chronology
[ ] Complete
_____ _____
_____ to _____
_____ _____

[ ] Temp Permit Issued Number: _____

7/12/06	7/12/06		✓
FSMB	AMA	ECFMG	Archive File

Personal Data "Yes"s	Documentation Received

Malpractice Cases	Synopsis	Disposition
1		
2		
3		
4		

Medical School School Code _____ [ ] U.S. [ ] Canadian [ ] International

Name DREXEL Year of Degree 2003 5/31/06 Transcripts [ ] Translations

Examination Type [ ] National Boards [ ] FLEX [x] USMLE [ ] State Exam [ ] LMCC 5/10/06 Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Graduate Training Programs	Accrediation Verified
XX	U OF CA 7/03-7/04				
7/12	GROUP HEALTH 5/05 - 6/07				
	WRONG DATES ON APP				

Received	State Licensure	Received	Hospital Privileges
7/12	IN		

Approved Signature Helen A Boyce Date 7/25/06

Comments:

Deficiency Letters:

[ ]	January	[ ]	April	[ ]	July	[ ]	October	[ ]	_____
[ ]	February	[ ]	May	[ ]	August	[ ]	November	[ ]	_____
[ ]	March	[ ]	June	[ ]	September	[ ]	December	[ ]	_____

Background Check Processed

JUL 0 6 2006

WSP/NPDB/HIPDB
Department of Health
Investigation Service Unit

Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4785
(360) 236-4784

FOR OFFICE USE ONLY

ISSUANCE DATE

LICENSE # 46899

LICENSE #

Application For License To Practice Medicine
Applicable For MD's Only

☐ National Boards ☐ Other State Exam ☐ LMCC (must have been obtained after 1969)

☐ FLEX Examination ☒ USMLE Examination

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

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

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL
	LUCAS	ANDREA	P

ADDRESS: 125 16TH AVE E, C5B160

CITY	STATE	ZIP	COUNTY
SEATTLE	WA	98112	KING

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.): (206) 310-2422

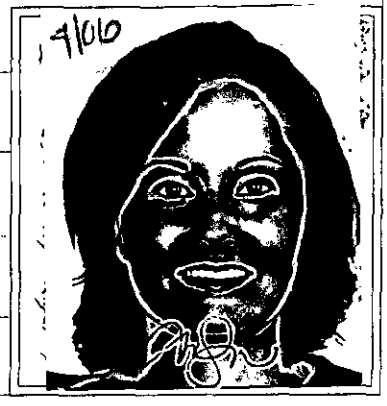
SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW): 1 - DOH Licensee Social Security Number - RCW 42.56.350(1)

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)
☒ Female ☐ Male	01/10/1974	Chula Vista, CA

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

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

If yes, list name(s): Andrea Paige Grace



HEIGHT	WEIGHT
5'2"	110

EYE COLOR	HAIR COLOR
green	brown

MEDICAL SCHOOL	YEAR OF GRADUATION
Drexel University College of Medicine	2003

MEDICAL SPECIALITY: Family Medicine

325 -

PHYSICIAN & SURGEON

Washington State Department of Health

REVENUE SECTION

PRINT NAME Lucas Andrea

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236

"0284"

0284-6/27/2006 4:24:03 PM-0601 $325.00

06178284

2. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

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

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

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

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

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

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

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

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

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

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

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☒
b. a charge of a sex offense?	☐	☒
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☒
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☒
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☒
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☒
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☒

Elliott, Betty (DOH)

From: Lucas, Andrea [lucas.a@ghc.org]
Sent: Wednesday, July 12, 2006 6:25 PM
To: Elliott, Betty (DOH)
Subject: RE:

Yes that is right 6/05 - present for total time at Group Health. Thank you very much.

Andrea Lucas

From: Elliott, Betty (DOH) [mailto:Betty.Elliott@DOH.WA.GOV]
Sent: Wednesday, July 12, 2006 1:09 PM
To: Lucas, Andrea
Subject:

I have reviewed your application and I believe your dates were written down wrong, you wrote that you were are Group health from 5/06-present, I believe it should have been 6/05-present, I will need you to correct that, you can email me the correction

Betty Elliott, Program Representative
WA State Department of Health
310 Israel Rd SE, Tumwater WA 98501
PUB 7866, Olympia WA 98504
Email: betty.elliott@doh.wa.gov
Work Phone: 360 236-4785
Fax Number: 360 236-4768
Web Address:www.doh.wa.gov/medical

"The Department of Health works to protect and improve the health of the people of Washington State"

2. Personal Data Questions (Continued)

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

3. Education And Experience

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

Schools Attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Number of Years Attended	Dates Attended From (mo/yr)	Dates Attended To (mo/yr)	Diploma or Degree Obtained (Quote titles in original language and translate to English.)
Medical Education (List all Medical Schools Attended)				
Drexel University College of Medicine	4	07/99	06/03	M.D.
Post-Graduate Training (List all Programs Attended)				
Group Health Cooperative	1	5/04	current	none
University of CA, Irvine	1	07/03	07/04	none

4. Professional Experience

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

	Dates of Experience From (mo/yr)	To (mo/yr)
none - see post graduate training		
Time Break - No work/employment/experience obtained	07/04	05/05

5. Hospital Privileges

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

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	Dates Beginning (mo/yr)	Dates Ending (mo/yr)
none		

6. Licenses In Other States

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

State, County or Province	Date License Issued	License Number	Basis of Licensure: Examination (Date Passed)	Basis of Licensure: Endorsement	Status of License: Active	Status of License: Inactive	Any Limitations on License
Indiana	2/2/05	01060182A	7/8/04 USMLE 3			X expired	☒ No ☐ Yes
Washington	8/25/05	ML20008178	7/8/04		X		☐ No ☒ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes

7. Fifth Pathway (foreign-trained applicants only) (Attach additional 8 1/2 X 11 sheets if necessary.)

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

8. AIDS Affidavit

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. 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. I understand that should I provide any false information, my registration may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE
AGL	5/2/06.

9. Applicant's Attestation

I, Andrea Paige-Grace Lucas, certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, 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 the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

Signature of Applicant

5/2/06

Date

Official Use Only

Washington State Records Center

HPQA
RECEIVED
JUN 28 2006
CSC

US·MLE
United States
Medical
Licensing
Examination™

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 05/10/2006

Recipient:

Washington Medical Quality Assurance Commission
ATTN: Doron Maniece, Exec Director
310 Isreal Road SE
Tumwater, WA 98501

Examinee: Lucas, Andrea
Alt Name(s): Grace, Andrea Paige
Lucas, Andrea P

Examinee ID#: 5-098-962-3
Date of Birth: 01/10/1974

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	12/29/2001	Pass	201	182	82	75	
	07/31/2001	Fail	174	182	71	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	04/18/2003	Pass	202	174	82	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
CALIFORNIA	07/08/2004	Pass	220	184	91	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

Interpretation of results

USMLE transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., "Incomplete." On those Step examinations for which numeric scores are reported, two different scales are used. The first is a three-digit score scale on which most scores fall between 140 and 280. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration. The second is a two-digit scale on which a score of 75 is the recommended minimum passing score. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points on the three-digit scale and 1 to 2 points on the two-digit scale.

STEP 2 CLINICAL SKILLS (CS)

The Clinical Skills (CS) component of Step 2 was introduced in 2004 and the USMLE transcript has been modified to reflect this change. The Step 2 examination that existed prior to the introduction of Step 2 CS continues to be administered as the Clinical Knowledge (CK) component of Step 2. The label "Step 2 CK" is used for this examination whether taken before or after the introduction of the Step 2 CS component.

Step 2 CS results are reported as pass or fail. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

Some individuals may be required to take and pass Step 2 CS prior to registering for Step 3. Transcript users can find information on eligibility requirements for all USMLE examinations in the *USMLE Bulletin of Information* and from periodic Step 2 CS updates, available at the USMLE website (www.usmle.org).

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed within this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

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

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record to the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

DREXEL UNIVERSITY

COLLEGE OF MEDICINE • 2900 QUEEN LANE • PHILADELPHIA, PA 19129

Date Issued: 23-MAY-2006
Official School of Medicine

Student No: 60007524

Record of: Andrea Paige Grace
Current Name: Andrea Paige Grace
Apt E205
2775 Mesa Verde Dr East
Costa Mesa, CA 92626

Issued To: Dept of Health
Medical Quality Ass Comm
P.O. Box 47866
Olympia, WA 98504-7866

Course Level: Medicine
Only Admit: Fall Semester 99-00
Matriculated: Fall Semester 99-00

Current Program
Doctor of Medicine
College: College of Medicine
Major: Medicine

Degrees Awarded: Doctor of Medicine 18-JUL-2003
Major: Medicine

SUBJ	NO	COURSE TITLE	GRD	R	PTS
INSTITUTION CREDIT:					
Fall Semester 99-00					
College of Medicine					
Medicine					
0000	800S	REGISTRATION INDICATOR			
CPMH	832S	MEDICINE AND RELIGION (S/U)	S		
PILM	710S	PIL BLOCK I	HS		
PILM	711S	FOCUS GROSS ANATOMY	+		
PILM	712S	HISTOLOGY	+		
PILM	713S	INTRO TO THE PATIENT	+		
Good Standing					
Winter Session 99-00					
College of Medicine					
Medicine					
PILM	720S	PIL BLOCK II	S		
PILM	721S	NEUROSCIENCE	+		
PILM	722S	PHYSIOLOGY	+		
PILM	723S	INTRO TO THE PATIENT	+		
Good Standing					
Spring Semester 99-00					
College of Medicine					
Medicine					
0000	800S	REGISTRATION INDICATOR			
CPMH	822S	HISTORY OF MEDICINE (S/U)	S		
CPMH	950S	COMPLIMENTARY & ALTERNATIVE ME	S		
PILM	730S	PIL BLOCK III	S		
PILM	731S	MICROBIOLOGY & IMMUNOLOGY	+		
PILM	732S	BIOCHEMISTRY	+		
PILM	733S	INTRO TO THE PATIENT	+		
Good Standing					
Summer Semester 99-00					
College of Medicine					
Medicine					
PILM	740S	PIL BLOCK IV	S		
PILM	741S	PRIMARY CARE PRACTICUM	+		
Fall Semester 00-01					
College of Medicine					
Medicine					
0000	800S	REGISTRATION INDICATOR			
PILM	750S	PIL BLOCK V	HS		
PILM	751S	FOUNDATION BASIC SCIENCE	+		
PILM	752S	PATHOLOGY	+		
PILM	753S	PATHOPHYSIOLOGY	+		
PILM	754S	PHARMACOLOGY	+		
PILM	756S	INTRO TO THE PATIENT	+		
PILM	757S	COMM CONTINUITY PRACTICUM	+		
PILM	758S	PSYCHOPATHOLOGY	+		
PILM	760S	PIL BLOCK VI	HS		
PILM	761S	FOUNDATION BASIC SCIENCE	+		
PILM	762S	PATHOLOGY	+		
PILM	763S	PATHOPHYSIOLOGY	+		
PILM	764S	PHARMACOLOGY	+		
PILM	765S	PSYCHIATRY	+		
PILM	766S	INTRO TO THE PATIENT	+		
PILM	767S	COMM CONTINUITY PRACTICUM	+		
Good Standing					
Spring Semester 00-01					
College of Medicine					
Medicine					
0000	800S	REGISTRATION INDICATOR			

********** CONTINUED ON NEXT COLUMN **********

********** CONTINUED ON PAGE 2 **********

RECEIVED
MAY 31 2006
HPS

AN OFFICIAL SIGNATURE IS WHITE WITH A BLUE BACKGROUND • REJECT DOCUMENT IF SIGNATURE BELOW IS DISTORTED

A black and white transcript is NOT an original • void appears if copied

Jerri A. Simmons, Registrar

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THIS IS AN OFFICIAL TRANSCRIPT OF RECORD PURSUANT TO THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974, AS AMENDED. THIS RECORD CANNOT BE RELEASED TO ANY OTHER PARTY WITHOUT WRITTEN CONSENT OF THE STUDENT.

NOTE: The column after GRD and PTS labeled R refers to whether or not certain repeatable courses are included (I) in the student's GPA. An (I) shown in this column indicates that the grade shown in the GRD column is included in the student's grade point average.

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Office of the Health Science's Registrar
2900 Queen Lane
Philadelphia, PA 19129-1096
(215) 991-8206

245 N. 15th Street, MS 445
Philadelphia, PA 19102-1192
(215) 762-7601

EXPLANATION OF TRANSCRIPT

Drexel University College of Medicine was part of MCP Hahnemann University prior to July 1, 2002; Allegheny University of the Health Sciences prior to November 10, 1998; known as Women's Medical College of Pennsylvania prior to May 8, 1970; known as Hahnemann Medical College and Hospital prior to August 20, 1982; and known as The Medical College of Pennsylvania and Hahnemann until June 20, 1996.

ACCREDITATION

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UNIT OF CREDIT

The Drexel University College of Medicine operates on a semester system. One credit hour represents one contact hour of recitation/ lecture, or two to three contact hours of laboratory per week for a full semester. The Drexel University College of Medicine grants the professional degree Doctor of Medicine as well as Master and Doctoral (Ph.D.) degrees and certificates. The College of Medicine does not assign credit hours to courses taken to satisfy the requirements for the Doctor of Medicine degree, but does for certificate, Master and Doctoral level courses.

EXPLANATION OF GRADES AND GRADE POINTS

Grade	Value
A+	4.30 quality points
A	4.00 quality points
A-	3.70 quality points
B+	3.30 quality points
B	3.00 quality points
B-	2.70 quality points
C+	2.30 quality points
C	2.00 quality points
C-	1.70 quality points
D+	1.30 quality points
D	1.00 quality points
D-	0.70 quality points
F	0.00 quality points
H	Honors
HP	High Pass (discontinued Fall 1992)
HS	Highly Satisfactory
P	Pass (discontinued Fall 2000)
S	Satisfactory
U	Unsatisfactory
AU	Audit
EX	Exemption (course previously taken)
W	Withdrawn
WP	Withdrawn Passing
WF	Withdrawn Failing
-	Registration Indicator
+	Courses within a Block
T	Transfer Credit

Temporary Grades

I	Incomplete
IP	In Progress
NGR	No Grade Reported
NR	No Grade Reported

EXPLANATION OF REPEATED COURSES

Courses with an indicator of "I" in the R column of the transcript will be included in the term and cumulative credits earned and GPAs; courses with an "E" in the R column will be excluded from the term and cumulative GPAs, but retained in term and cumulative credits attempted; courses with an "A" in the R column will be excluded from the term and cumulative credits earned, but retained in term and cumulative credits attempted and calculated in the term and cumulative GPAs.

Recipients of this transcript are obligated to comply with Section 438 of Public Law 93-380 (Family Educational Rights and Privacy Act of 1974, as amended). This transcript of information is sent to you at the request of the student, but only on the condition that you will not permit any other party to have access to this information without the written consent of the student. If you are unable to comply fully with this requirement, return this record to us immediately.

DREXEL UNIVERSITY

COLLEGE OF MEDICINE • 2900 QUEEN LANE • PHILADELPHIA, PA 19129

Student No: 60007524

Date Issued: 23-MAY-2006
Official School of Medicine

Record of: Andrea Paige Grace
Level: Medicine

SUBJ	NO.	COURSE TITLE	GRD	R
Institution Information continued:				
PILM	770S	PIL BLOCK VII	S	
PILM	771S	FOUNDATION BASIC SCIENCE	+	
PILM	772S	PATHOLOGY	+	
PILM	773S	PATHOPHYSIOLOGY	+	
PILM	774S	PHARMACOLOGY	+	
PILM	775S	PSYCHIATRY	+	
PILM	776S	INTRO TO THE PATIENT	+	
PILM	777S	COMM CONTINUITY PRACTICUM	+	
PILM	778S	CLINICAL SKILLS	HS	
Good Standing				
Fall Semester 01-02				
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR		
PSYC	801S	PSYCHIATRY	S	
Good Standing				
Spring Semester 01-02				
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR		
OBGY	801OS	OBSTETRICS & GYNECOLOGY	HS	
PEDS	801OS	PEDIATRICS	S	
SURG	801OS	SURGERY	S	
Good Standing				
Fall Semester 02-03				
PEDS	911	Ped HIV Infection & Other Immunological Disorders - 2WKS		
College of Medicine				
Medicine				
FAMD	801OS	FAMILY MEDICINE	HS	
MEDI	801OS	MEDICINE	HS	
NEUL	801 4S	NEUROLOGY	HS	
PEDS	911 4S	PED HIV & OTHER IMMUN DISORDER	HS	
SURG	881 2S	PED PLAST&RECONSTRUC SURG-2WKS	H	
Good Standing				

********** CONTINUED ON NEXT COLUMN **********

SUBJ	NO.	COURSE TITLE	GRD	R
Institution Information continued:				
Spring Semester 02-03				
College of Medicine				
Medicine				
ANES	821 2S	CLINICAL ANESTHESIOLOGY-2WKS	HS	
DERM	811 4S	CLINICAL DERMATOLOGY	H	
FAMD	811 4S	FAMILY MEDICINE	H	
MEDI	850 4S	MEDICINE SUBINTERNSHIP	S	
OMED	841 4S	CHANNEL 6 HEALTH CHECK	H	
PEDS	850 4S	SUBINTERNSHIP IN PEDIATRICS	HS	
PEDS	991 4S	NEONATAL MED SUBINTERNSHIP	S	
PSYC	821 4S	CONSULT - LIAISON PSYCHIATRY	H	
Good Standing				
Fall Semester 03-04				
College of Medicine				
Medicine				
OMED	841 2S	MEDIA &PUBLIC HLTH ISSUES -2WK	H	
Good Standing				

********** END OF TRANSCRIPT **********

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College of Medicine
2900 Queen Lane
Philadelphia, PA 19129-1096

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OFFICIAL DOCUMENT
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OPEN IMMEDIATELY

PHILADELPHIA PA 191
25 MAY 200
02 1A $ 00.39⁰
0004609835 MAY 25 2006
MAILED FROM ZIPCODE 19102
05/25/2006 07:57 PM

Department of Health
Medical Quality Assurance Commission
1300 Quince Street
P.O. Box 47866
Olympia, Wa 98504

OFFICIAL TRANSCRIPT
Do not break signature seal

Joseph J. Salimone

University Registrar
Drexel University

Washington State Department of Health

MD

TO: Post Graduate Training Program Director

University of California, Irvine Dept of Family Medicine
FACILITY NAME

101 The City Drive South, Bldg 200, Rte 81, Ste 512
ADDRESS

Orange, CA 92868-3298

RE: Verification/Evaluation of Training

RECEIVED
MAY 3 2005
DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

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.**

ANDREA LUCAS (formerly ANDREA GRACE) — APPLICANT (PRINT OR TYPE)

01-10-1974 — BIRTHDATE

SIGNATURE OF APPLICANT

1. Andrea Lucas, M.D. is or was engaged in postgraduate training in our program

from July 28, 2003 (BEGINNING DATE (MONTH & YEAR)) to July 30, 2004 (ENDING DATE (MONTH & YEAR))

in the field of Family Medicine.

2. **At the time this individual was in training, was this program accredited through the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons, or the College of Family Physicians of Canada?** ☒ Yes ☐ No

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 _____

Return to:

Medical Quality Assurance Commission
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(SEAL)

Signature C Vega, MD

Title Residency Program Director

Hospital University of California, Irvine
PLEASE TYPE OR PRINT

Address 101 City Drive South,
Orange, CA 92868-3298

Date _____

Telephone (714) 456-6502

DOH 657-034 (REV 10/2003)

Washington State Department of Health

MD

TO: Post Graduate Training Program Director

Group Health Cooperative
FACILITY NAME

125 16th Ave E, CSB 160
ADDRESS

Seattle, WA 98112

RECEIVED
JUL 12 2006
DEPARTMENT OF HEALTH PROFESSIONS

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.**

APPLICANT (PRINT OR TYPE) Andrea Lucas BIRTHDATE 01-10-74

SIGNATURE OF APPLICANT

1. Andrea Lucas *is or was engaged in postgraduate training in our program*

from 5/25/2005 to 6/27/2007
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

in the field of Family Medicine

2. **At the time this individual was in training, was this program accredited through the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons, or the College of Family Physicians of Canada?** ☒ Yes ☐ No

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 _____

Return to:

Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(SEAL)

Signature

Title Program Director

Hospital Group Health Cooperative
PLEASE TYPE OR PRINT

Address 125 16th Ave E, CSB 160
Seattle, WA 98112

Date 6/7/06

Telephone (206) 326-3082

DOH 657-034 (REV 7/2004)

Indiana
Online Licensing

Person Information

Name: Andrea Paige Lucas
Birth: 1/10/1974

Address Information

Address:
135 Ledgewood Rd. Apt 110
Groton CT 06340

License Information

License No: 01060182A
Profession: Medical Licensing Board
License Type: Physician
Issue Date: 2/2/2005
Expiration Date: 6/30/2005
License Status: Expired

Previous Action

Previous Action- None

You may close this window to return to your search results

- If this practitioner has disciplinary action indicated above by the license status (Probation, Revoked, Suspended, etc)
or has Previous Action indicated, you can link to the board and e-mail the board staff for more information. **Click Here**

- The above information is available to the general public unrestricted. If you need additional information, it is available from Access Indiana. The additional information includes: full address of record as provided by the practitioners, date of birth (if available).

- To obtain the additional information from Access Indiana and you are a subscriber, Click on **Subscriber Search**

- If you are NOT a subscriber and want the additional information using a credit card, please click on **Credit Card Search**

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

July 12, 2006

Attn: Blake Maresh, Exec Dir.
Washington Quality Med Assur
310 Israel Road SE
PO Box 47860
Tumwater, WA 98501

Re: Board Action Query Dated: July 12, 2006
Your Reference Number:
FSMB Batch Number: BQ1265773

The following is a report of the search results from the Board Action Data Bank as of July 12, 2006 for practitioners submitte referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of July 12, 2006

Item	Name	DOB	School	Yr/Grad
1	Agler, David	03/26/1975	005080	2004
9	Baldwin, Timothy	03/01/1954	044080	1983
2	Burns, amy	02/18/1972	017010	2003
4	Gopinath, Shamin	12/28/1976	044010	2003
5	Kim, Hojoong	02/13/1975	014040	2002
6	Lee, Naomi	08/07/1973	048010	2003
8	Levine, Brian	11/02/1974	003010	2002
7	Lucas, Andrea	01/10/1974	039100	2003

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

ANDREA PAIGE LUCAS MD
APT 1
2009 43RD AVE E
SEATTLE WA 98112-2765

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: UNKNOWN

Birthdate: 01/10/1974
Birthplace: CHULA VISTA, CA UNITED STATES OF AMERICA

Physician's Major Professional Activity: HOSPITAL BASED RESIDENTS - ALL YEARS

Practice Specialties Self Designated by the Physician*:

Primary Specialty: FAMILY PRACTICE

Secondary Specialty: UNSPECIFIED

"Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

DREXEL UNIV COLL OF MED, PHILADELPHIA PA 19129

Degree Awarded: Yes

Degree Year: 2003

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

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

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: UNIV CA IRVINE MED CTR — **State:** CALIFORNIA
Specialty : FAMILY PRACTICE — 07/2003 - 07/2004 ** (VERIFIED)

****INCOMPLETE TRAINING: Program reports Specialty training at this institution as 'Incomplete'**

Institution: GROUP HLTH COOP/PUGET SOND — **State:** WASHINGTON
Specialty : FAMILY PRACTICE — 06/2005 - 06/2007 (BEING REVERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
WASHINGTON	MD	05/25/2005	06/30/2006	ACTIVE	LIMITED	06/15/2006
INDIANA	MD	02/02/2005	06/30/2005	INACTIVE	UNLIMITED	07/15/2005

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certfication:

Applicant Number:

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

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Federal Drug Enforcement Administration:

* *Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
XXXXXX527	22N 33N 4 5	03/31/2009	06/12/2006

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

Specialty Board Certification(s)*:

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

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA).

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:

Duration	Effective	Expiration	Occurrence	Last Reported

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

Medicare/Medicaid Sanction(s):

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

Other Federal Sanction(s):

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

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Additional Information:

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

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

If you note any discrepancies, please log onto our web site (http://www.ama-assn.org/go/amaprofiles) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

May 19, 2006

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 1099
Olympia, WA 98507-1099

To Whom It May Concern:

This letter is to accompany my application for permanent licensure in the state of Washington.

1) I have submitted an online request for USMLE transcript through the FSMB. There is a drop down menu listing the WA MQAC with the address of "310 Isreal Rd. SE, Tumwater, WA 98501, Attn: Doron Maniece, Exec Director". There is not an option to change this address. I am concerned because on the application, all other documents are to be sent to the Olympia address. Do you obtain this transcript from Tumwater or how is the information obtained by your office?

2) The documentation of my previous (now expired) IN license and internship training which was at UC Irvine. Please let me know if this information was in my archived file or if I need to request this again from these places.

3) The forms for verification of hospital privileges, liability action history and ECFMG are not applicable.

4) Medical school transcripts have been requested and are in process now.

Thank you for processing my application. If you have any questions, please don't hesitate to contact me.

Sincerely,

Andrea Paige-Grace Lucas, MD
Formerly Andrea Paige Grace, MD
2009 43rd Ave East, #1
Seattle, WA 98112
(206) 370-2422
lucas.a@ghc.org

Medical Quality Assurance Commission
Limited License Application Worksheet

Name LUCAS ANDREA Date of Birth 01/10/1974

Date Received 5/12/05 Cash Number 051301579 Candidate Number

x	WSP Check	x	Fee	x	Photo	x	Data1-13	x	AIDS	x	Attest	x	SSN	x	Garfield Search

Chronology Complete

Missing: ____ to ____; ____ to ____; ____ to ____

[x] Residency [ ] Institution [ ] Fellowship [ ] City/County [ ] Teaching/Research

FSMB 5/12/05

AMA 5/12/05

Personal Data "Yes"s	Documentation Received	Malpractice Cases	Synopsis	Disposition
		1		
		2		
		3		
		4		

Medical School School Code ____ [ ] U.S. [ ] Canadian [ ] International

Name HAHNEMANN Year of Degree 2003 [x] Transcripts [ ] Translations

Examination Type [ ] National Boards [ ] FLEX [ ] USMLE [ ] State Exam [ ] LMCC [ ] Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Graduate Training Programs	Accrediation Verified
x	U OF CA 7/03-7/04				

Received	State Licensure	Received	Hospital Privileges
x	IN		

Received	Program/Employment Verification	Received	Program/Employment Verification
5/12/05	GROUP HEALTH 5/25/2005		

Approved Helen A. Day Date 6/3/05

Comments:

Deficiency Letters:

[ ] January [ ] February [ ] March [ ] April [ ] May [ ] June [ ] July [ ] August [ ] September [ ] October [ ] November [ ] December [ ] ____ [ ] ____ [ ] ____

R04 Washington State Department of Health 225—

LIMITED PHYSICIAN

REVENUE SECTION

PRINT NAME Lucas, A-

LF 0252140000 00335

001579 05/10/2005 22500

Washington State Department of Health

BACKGROUND CHECK PROCESSED

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

MAY 12 2005

Department of Health
Investigation Service Unit

FOR OFFICE USE ONLY
ISSUANCE DATE
LICENSE # 8178

LICENSE #

Application For Limited License To Practice Medicine
Applicable For MD's Only

☒ Internship—Residency ☐ Teaching—Research ☐ Institution
☐ Fellowship (2 year limit) ☐ County—City Health Department

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

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

1. Demographic Information

APPLICANT'S NAME — LAST: LUCAS — FIRST: ANDREA — MIDDLE INITIAL: P

NAME OF INSTITUTION/HEALTH DEPT./MEDICAL SCHOOL/HOSPITAL: GROUP HEALTH COOPERATIVE

ADDRESS: 125 10th Ave. EAST CSB 160

CITY: SEATTLE | STATE: WA | ZIP: 98112-5211 | COUNTY: King

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.): (860) 449 0239

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW): *1 - DOH Licensee Social Security Number - RCW 42.56.350(1)*

GENDER: ☒ Female ☐ Male | BIRTHDATE (MO/DAY/YEAR): 01/10/1974 | PLACE OF BIRTH: CHULA VISTA, CA

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

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

If yes, list name(s): ANDREA GRACE

HEIGHT: 5'2" | WEIGHT: 110 pounds

EYE COLOR: green | HAIR COLOR: brown

MEDICAL SCHOOL: MCP. Hahnemann / Drexel University | YEAR OF GRADUATION: 2003

MEDICAL SPECIALITY: FAMILY MEDICINE

2. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

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

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

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

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

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

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

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

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

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

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

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☒
b. a charge of a sex offense?	☐	☒
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☒
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☒
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☒
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☒
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☒

2. Personal Data Questions (Continued)

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

3. Education And Experience

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

SCHOOLS ATTENDED (LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.)	NUMBER OF YEARS ATTENDED	DATES ATTENDED FROM (MO/YR)	DATES ATTENDED TO (MO/YR)	DIPLOMA OR DEGREE OBTAINED (QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.)
Medical Education (List all Medical Schools Attended)				
MCP Hahnemann / Drexel University	4	07/99	06/99	M.D.
Post-Graduate Training (List all Programs Attended)				
University of CA, Irvine Family Medicine	1	07/03	07/04	

4. Professional Experience

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

	DATES OF EXPERIENCE FROM (MO/YR)	DATES OF EXPERIENCE TO (MO/YR)
See above - post-graduate training		

5. Hospital Privileges

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

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	DATES BEGINNING (MO/YR)	DATES ENDING (MO/YR)
- NONE -		

6. Licenses In Other States

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

STATE, COUNTY OR PROVINCE	DATE LICENSE ISSUED	LICENSE NUMBER	BASIS OF LICENSURE		STATUS OF LICENSE		ANY LIMITATIONS ON LICENSE
			EXAMINATION (DATE PASSED)	ENDORSEMENT	ACTIVE	INACTIVE	
INDIANA	2/2/05	01040182A	N/A	Verified Internship	X		☑ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes

7. Fifth Pathway (foreign-trained applicants only) (Attach additional 8 1/2 X 11 sheets if necessary.)

NAME AND LOCATION OF FIFTH PATHWAY PROGRAM	NAME AND LOCATION OF HOSPITAL	DATES ATTENDED	
		BEGINNING (MO/YR)	ENDING (MO/YR)

8. AIDS Affidavit

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. 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. I understand that should I provide any false information, my registration may be denied, or if issued, suspended or revoked.

APPLICANTS INITIALS	DATE
AJ	4/26/05

9. Applicant's Attestation

I, Andrea Lucas, MD, certify that I am the person described and identified
NAME OF APPLICANT

in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, 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 the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

SIGNATURE OF APPLICANT

4/26/05
DATE

Official Use Only

Washington State Records Center

HPQA RECEIVED MAY 11 2005

DREXEL UNIVERSITY

COLLEGE OF MEDICINE • 2900 QUEEN LANE • PHILADELPHIA, PA 19129

Student No: 600-07-524

Date Issued: 13-MAY-2005
OFFM

Record of: Andrea Paige Grace
Apt E205
2775 Mesa Verde Dr East
Costa Mesa, CA 92626

Issued To: Department of Health
Medical Quality
Assurance Commission
PO Box 47866
Olympia, WA 98504-7866

Course Level: Medicine
Only Admit: Fall Semester 99-00
Matriculated: Fall Semester 99-00

Current Program
College : College of Medicine
Major : Medicine
Conc (s) : Program in Integrated Learning

Degree Awarded : Doctor of Medicine 18-JUL-2003
Major : Medicine
Concentration(s): Program in Integrated Learning

SUBJ NO.	COURSE TITLE	GRD	R
INSTITUTION CREDIT:			
Fall Semester 99-00			
College of Medicine			
Medicine			
0000 800S	REGISTRATION INDICATOR		
CPMH 832S	MEDICINE AND RELIGION (S/U)	S	
PILM 710S	PIL BLOCK I	HS	
PILM 711S	FOCUS GROSS ANATOMY	+	
PILM 712S	HISTOLOGY	+	
PILM 713S	INTRO TO THE PATIENT	+	
Good Standing			
Winter Session 99-00			
College of Medicine			
Medicine			
PILM 720S	PIL BLOCK II	S	
PILM 721S	NEUROSCIENCE	+	
PILM 722S	PHYSIOLOGY	+	
PILM 723S	INTRO TO THE PATIENT	+	
Good Standing			
Spring Semester 99-00			

********** CONTINUED ON NEXT COLUMN **********

SUBJ NO	COURSE TITLE	GRD	R
Institution Information continued:			
College of Medicine			
Medicine			
0000 800S	REGISTRATION INDICATOR		
CPMH 822S	HISTORY OF MEDICINE (S/U)	S	
CPMH 950S	COMPLIMENTARY & ALTERNATIVE ME	S	
PILM 730S	PIL BLOCK III	S	
PILM 731S	MICROBIOLOGY & IMMUNOLOGY	+	
PILM 732S	BIOCHEMISTRY	+	
PILM 733S	INTRO TO THE PATIENT	+	
Good Standing			
Summer Semester 99-00			
College of Medicine			
Medicine			
PILM 740S	PIL BLOCK IV	S	
PILM 741S	PRIMARY CARE PRACTICUM	+	
Fall Semester 00-01			
College of Medicine			
Medicine			
0000 800S	REGISTRATION INDICATOR		
PILM 750S	PIL BLOCK V	HS	
PILM 751S	FOUNDATION BASIC SCIENCE	+	
PILM 752S	PATHOLOGY	+	
PILM 753S	PATHOPHYSIOLOGY	+	
PILM 754S	PHARMACOLOGY	+	
PILM 756S	INTRO TO THE PATIENT	+	
PILM 757S	COMM CONTINUITY PRACTICUM	+	
PILM 758S	PSYCHOPATHOLOGY	+	
PILM 760S	PIL BLOCK VI	HS	
PILM 761S	FOUNDATION BASIC SCIENCE	+	
PILM 762S	PATHOLOGY	+	
PILM 763S	PATHOPHYSIOLOGY	+	
PILM 764S	PHARMACOLOGY	+	
PILM 765S	PSYCHIATRY	+	
PILM 766S	INTRO TO THE PATIENT	+	
PILM 767S	COMM CONTINUITY PRACTICUM	+	
Good Standing			

********** CONTINUED ON PAGE 2 **********

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Jerri A. Simmons, Registrar

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NOTE: The column after GRD and PTS labeled R refers to whether or not certain repeatable courses are included (I) in the student's GPA. An (I) shown in this column indicates that the grade shown in the GRD column is included in the student's grade point average.

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Office of the Health Science's Registrar
2900 Queen Lane
Philadelphia, PA 19129-1096
(215) 991-8206

245 N. 15th Street, MS 445
Philadelphia, PA 19102-1192
(215) 762-7601

EXPLANATION OF TRANSCRIPT

Drexel University College of Medicine was part of MCP Hahnemann University prior to July 1, 2002; Allegheny University of the Health Sciences prior to November 10, 1998; known as Women's Medical College of Pennsylvania prior to May 8, 1970; known as Hahnemann Medical College and Hospital prior to August 20, 1982; and known as The Medical College of Pennsylvania and Hahnemann until June 20, 1996.

ACCREDITATION

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EXPLANATION OF GRADES AND GRADE POINTS

Grade	Value
A+	4.30 quality points
A	4.00 quality points
A-	3.70 quality points
B+	3.30 quality points
B	3.00 quality points
B-	2.70 quality points
C+	2.30 quality points
C	2.00 quality points
C-	1.70 quality points
D+	1.30 quality points
D	1.00 quality points
D-	0.70 quality points
F	0.00 quality points
H	Honors
HP	High Pass (discontinued Fall 1992)
HS	Highly Satisfactory
P	Pass (discontinued Fall 2000)
S	Satisfactory
U	Unsatisfactory
AU	Audit
EX	Exemption (course previously taken)
W	Withdrawn
WP	Withdrawn Passing
WF	Withdrawn Failing
-	Registration Indicator
+	Courses within a Block
T	Transfer Credit

Temporary Grades

I	Incomplete
IP	In Progress
NGR	No Grade Reported
NR	No Grade Reported

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DREXEL UNIVERSITY

COLLEGE OF MEDICINE • 2900 QUEEN LANE • PHILADELPHIA, PA 19129

Student No: 600-07-524

Date Issued: 13-MAY-2005

OFFM

Record of: Andrea Paige Grace
Level: Medicine

SUBJ	NO.	COURSE TITLE	GRD	R
Institution Information continued:				
Spring Semester 00-01				
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR		
PILM	770S	PIL BLOCK VII	S	
PILM	771S	FOUNDATION BASIC SCIENCE	+	
PILM	772S	PATHOLOGY	+	
PILM	773S	PATHOPHYSIOLOGY	+	
PILM	774S	PHARMACOLOGY	+	
PILM	775S	PSYCHIATRY	+	
PILM	776S	INTRO TO THE PATIENT	+	
PILM	777S	COMM CONTINUITY PRACTICUM	+	
PILM	778S	CLINICAL SKILLS	HS	
Good Standing				
Fall Semester 01-02				
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR		
PSYC	801S	PSYCHIATRY	S	
Good Standing				
Spring Semester 01-02				
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR		
OBGY	8010S	OBSTETRICS & GYNECOLOGY	HS	
PEDS	8010S	PEDIATRICS	S	
SURG	8010S	SURGERY	S	
Good Standing				
Fall Semester 02-03				
PEDS 9114 Ped HIV Infection & Other Immunological Disorders 2WKS				
College of Medicine				
Medicine				
FAMD	8010S	FAMILY MEDICINE	HS	
MEDI	8010S	MEDICINE	HS	
NEUL	8014S	NEUROLOGY	HS	

********** CONTINUED ON NEXT COLUMN **********

SUBJ	NO.	COURSE TITLE	GRD	R
Institution Information continued:				
PEDS	9114S	PED HIV & OTHER IMMUN DISORDER	HS	
SURG	8812S	PED PLAST&RECONSTRUC SURG-2WKS	H	
Good Standing				
Spring Semester 02-03				
College of Medicine				
Medicine				
ANES	8212S	CLINICAL ANESTHESIOLOGY-2WKS	HS	
DERM	8114S	CLINICAL DERMATOLOGY	H	
FAMD	8114S	FAMILY MEDICINE	H	
MEDI	8504S	MEDICINE SUBINTERNSHIP	S	
OMED	8414S	CHANNEL 6 HEALTH CHECK	H	
PEDS	8504S	SUBINTERNSHIP IN PEDIATRICS	HS	
PEDS	9914S	NEONATAL MED SUBINTERNSHIP	S	
PSYC	8214S	CONSULT--LIAISON PSYCHIATRY	H	
Good Standing				
Fall Semester 03-04				
College of Medicine				
Medicine				
OMED	8412S	MEDIA &PUBLIC HLTH ISSUES -2WK	H	
OMED	8414S	CHANNEL 6 HEALTH CHECK	NGR	
Good Standing				

********** END OF TRANSCRIPT **********

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College of Medicine
2900 Queen Lane
Philadelphia, PA 19129-1096

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Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866

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Health Professions Bureau

402 West Washington Street, Room W066
Indianapolis, Indiana 46204

Telephone (317) 234-2064
Fax (317) 233-4236
Website: www.IN.gov/hpb

May 18, 2005

Medical Quality Assurance Commission
P O Box 47866
Olympia WA 98504-7866

To Whom It May Concern:

THIS IS TO CERTIFY THAT:	Andrea Paige Lucas
BECAME A LICENSED:	Physician
NUMBER ISSUED:	01060182A
ISSUANCE DATE:	02/02/2005
EXPIRATION DATE:	06/30/2005
STATUS:	Active
BASIS OF LICENSURE:	Examination
SCHOOL/GRADUATION DATE:	Drexel, Philadelphia, PA 07/18/2003

Our agency has recently converted to a new computer system that has incorporated month and day to the graduation date. However, our old system only indicated year of graduation. You will find the graduation date listed 01/01/YYYY. Please consider the verification valid although the graduation date may conflict with the applicant's official academic transcripts.

Unless otherwise indicated, the State of Indiana has not disciplined this license. If other information is needed, please contact our office at (317) 234-2060 or via email at hpb3@hpb.in.gov

Jeanette Roberts

Jeanette Roberts, Assistant Director
Indiana Medical Board

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia WA 98504-7866
(360) 753-2844
(360) 664-8689

LMT

Medical Quality Assurance Commission

Residency Certification

This is to certify that Andrea Lucas has been

appointed as a resident* in Family Medicine (SERVICE) at

the Group Health Cooperative hospital for the period

beginning May (MONTH) 25 (DAY) 2005 (YEAR). The individual responsible for this resident's patient care activities

will be Fred Heidman MD (SIGNATURE) DIRECTOR OF PROGRAM.

*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)

DOH 657-057 (REV 10/2003)

American Medical Association

Physicians dedicated to the health of America

Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/go/amaprofiles

AMA Physician Profile

Name and Mailing Address:

ANDREA PAIGE GRACE MD
APT 110
135 LEDGEWOOD RD
GROTON CT 06340-6609

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: UNKNOWN

Birthdate: 01/10/1974
Birthplace: CHULA VISTA, CA UNITED STATES OF AMERICA

Physician's Major Professional Activity: NOT CLASSIFIED

Practice Specialties Self Designated by the Physician*:

Primary Specialty: UNSPECIFIED

Secondary Specialty:

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

DREXEL UNIV COLL OF MED, PHILADELPHIA PA 19129
Degree Awarded: Yes
Reported Year of Graduation 2003

American Medical Association

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515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/go/amaprofiles

AMA Physician Profile

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

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: UNIV CA IRVINE MED CTR — **State:** CALIFORNIA
Specialty : FAMILY PRACTICE — 07/2003 - 07/2004 ** (VERIFIED)

****INCOMPLETE TRAINING: Program reports Specialty training at this institution as 'Incomplete'**

Note: **If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.**

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
NONE REPORTED TO DATE						

Note: **When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.**

ECFMG Certfication:

Applicant Number:

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

Federal Drug Enforcement Administration:

* *Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
None	Reported		

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

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AMA Physician Profile

Specialty Board Certification(s)*:

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

The AMA Physician Profile has been designated by the ABMS as an official "display agent" of the ABMS Specialty Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA).

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:

Duration	Effective	Expiration	Occurrence	Last Reported

Note: **For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.**

Medicare/Medicaid Sanction(s):

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

Other Federal Sanction(s):

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

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AMA Physician Profile

Additional Information:

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

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

If you note any discrepancies, please log onto our web site and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

May 13, 2005

Attn: Blake Maresh, Exec Dir.
Washington Quality Med Assur
310 Israel Road SE
PO Box 47860
Tumwater, WA 98501

Re: Board Action Query Dated: May 12, 2005
Your Reference Number:
FSMB Batch Number: BQ1131429

The following is a report of the search results from the Board Action Data Bank as of May 12, 2005 for practitioners submitte referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 12, 2005

Item	Name	DOB	School	Yr/Grad
11	Benitez, Sara	06/24/1976	006010	2002
1	Bernhart, kristin	05/24/1974	039100	2005
12	Byker, Meralee	09/27/1952	099690	1980
13	Ctvrtnicek, Scarlett	09/18/1969	099581	1994
3	Engel, David	09/13/1974	005050	2005
15	Fortney, Michael	10/23/1967	035010	1996
6	Gaaserud, Annelise	12/01/1975	550025	2004
7	Hubert, Kristin	05/29/1976	022040	2003
14	Ingalsbe, Sarah	12/16/1980	099739	2003
9	Jost, Amanda	06/03/1979	033110	2005
8	Karpanian, Hagop	10/27/1977	050010	2004
16	Liou, Wayne	08/30/1968	023040	1996
10	Lucas, Andrea	01/10/1974	039010	2003

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

May 19, 2005

Andrea Lucas MD
Group Health Cooperative
125 16th Ave East CSB 160
Seattle WA 98112

Dear Dr Lucas

This is to acknowledge receipt of your application to obtain a **Residency** license in the state of Washington.

Your application and fee of $225.00 was received on May 6, 2005

MISSING ITEMS
Medical School Transcripts
Post Graduate Training Verification
State License Verification

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

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

If you have any further questions or need additional information, please feel free to call me at (360) 236-4785, email me at betty.elliott@doh.wa.gov, or write to me at Department of Health, Medical Quality Assurance Commission, P O Box 47866, Olympia, WA 98504-7866.

Sincerely,

Betty Elliott
Licensing Representative

telnet (GothomCity)

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                     AAAAAAA    SSS  SSS   IIIIIIIIII
                    AAAAAAAA   SSS    SSS      III
MEDICAL BOARD            ASSESSMENT SYSTEMS, INC.                  05-18-05
bje1303                        REAL SYSTEM          V2.5.74        11:21:25 AM
INDIVIDUAL NAME                 (JR,SR,III)          REFERENCE # CA00007521
   LAST LUCAS                                        SOC SEC NUM [1 - DOH Licensee Soci...]
  FIRST ANDREA                    +-ADDITIONAL INFORMATION----------------+
 MIDDLE P                         |          SEX F =      MARRIED Y =      |
                                  |                                        |
RESIDENCE INFORMATION              |   OTHER NAME                           |
GROUP HEALTH COOPERATIVE           |CORP. OFFICER                       =   |
125 16TH AVE EAST CSB 760          |TRUST ACCOUNT                           |
SEATTLE WA 98112                   |                                        |
                                   |  BIRTH PLACE CHULA VISTA CA            |
                                   |        DATE 01-10-1974                 |
PHONE: (   )    -      COUNTY:  17 |                                        |
       (   )    -      LGL ST:     |SCHOOL CODE 039010                      |
                                   |   CE UNITS    0.00 REQD BY   -  -      |
NOTES                              +----------------------------------------+

+-------------------------------------------------------------------------------+
|CURRENT STATUS: U    EXPIRATION DATE:   -  -      FIRST ISSUE DATE:   -  -     |
|RENEWAL STATUS:     LAST ACTIVE DATE:   -  -     LAST RENEWAL DATE:   -  -     |
|COMPLAINTS O/C:  0/ 0      AUTHORITY:                                          |
+-------------------------------------------------------------------------------+
1GO BACK  2NAM&ADDR 3EDUCATE  4LIC FUNC 5INVESTG  6         7OTHR DAT 8EXTD NOT
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Application File_447847_pdf-r.pdf redacted on: 12/16/2014 09:10

Redaction Summary (4 redactions)

1 Privilege / Exemption reason used:

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

Page 4, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 6, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 33, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 50, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance