

19539  
APPLICATION FOR

LICENSE TO PRACTICE

5106 9-1-81 75.00

(Check one)

MEDICINE  
 OSTEOPATHIC MEDICINE AND SURGERY

MONEY CTL.

FEEES  
Medicine with exam \$175.00  
Medicine w/o exam \$150.00  
Osteopathic Medicine and Surgery \$150.00

DEPARTMENT OF LICENSING  
DIVISION OF PROFESSIONAL LICENSING  
P. O. BOX 9649  
OLYMPIA, WA 98504

Make remittance payable to:  
STATE TREASURER

Note: If you have a Limited License to Practice then the fee with exam is \$100.00 and without exam is \$75.00

Application for licensure is made by: (Check one)

- National Board waiver.
- Reciprocity from (state) \_\_\_\_\_
- Washington Examination. (FLEX)
- L. M. C. C.
- Flex waiver.

FOR OFFICE USE ONLY

PROG	TRANS	PROF CODE	PIC/CIC	EXPIRATION DATE	EXPT	STAT	TYPE
LA		252					
KEY DATE	CLASS	ASSN	BILLED AMOUNT	SIGN	SPLIT	QTRD	

MI-HA-LL-S4700J 0 00-00-00  
MIHALOV, LINDA S

APPLICANT'S NAME MIHALOV LINDA S.  
Last First Middle

ADDRESS 152 NE 53RD ST.

CITY SEATTLE STATE WA ZIP 98105 COUNTY KING

TELEPHONE NO. 543-3333 SOCIAL SECURITY NUMBER 1 - DOH Licensee Social Security Number - RCW 4...  
Enter the number at which you can be reached during normal business hours. Requested for identification purposes only. Entering SSN is voluntary and is not required for licensing approval.

SEX (For M) F DATE OF BIRTH 11 11 53  
mo. day yr.

BIRTHPLACE BRIDGEPORT CT FAIRFIELD  
City State County

MEDICAL SPECIALTY OB/GYN

OFFICE USE ONLY	
EXAM DATE	_____
VOTER DIST.	_____
GRAD YR/SCH	_____

Medical/Osteopathic School UNIVERSITY OF ILLINOIS Year Graduated 1980

INSTRUCTIONS

1. ALL APPLICANTS
  - (a) This application and supporting documents, should be filed with the Division of Professional Licensing at least thirty (30) days prior to the board meeting at which it is to be reviewed. (Or for Flex exam by April 1 for the June examination and October 1 for the December examination.)
  - (b) If additional space is required, attach separate (8 1/2 x 11 inch) sheets indicating the section to which they refer.
  - (c) COPIES OF ALL DOCUMENTS MUST BE CERTIFIED AS TRUE AND NOTARIZED.
  - (d) ALL APPLICATIONS MUST BE ACCOMPANIED BY APPLICABLE FEE. FEES ARE NON-REFUNDABLE.

JUL 22 1981

# APPLICANTS MUST PROVIDE THE FOLLOWING

## 2. CERTIFICATION

- (a) Applicants for licensure by NATIONAL BOARD WAIVER must furnish "Certification of Record" direct from the National Board of Medical Examiners, 3930 Chestnut Street, Philadelphia, Penn. 19104, OR the National Board of Examiners for Osteopathic Physicians & Surgeons, 22 S. Washington St., Park Ridge, Ill., 60068.
- (b) Applicants for licensure by FLEX WAIVER must furnish examination results direct from FLEX office, 2626- B West Freeway, Fort Worth, Texas 76102.
- (c) Applicants for licensure by L.M.C.C. must furnish certification direct from The Medical Council of Canada, 1867 Alta Vista Dr., Box 8234, Ottawa, Ontario K1G 3H7.
- (d) Applicants for licensure by STATE RECIPROCITY must have Page 4 of the application completed.

## 3. MEDICINE ONLY

- (a) Copy of diploma issued by a medical school approved by the Board of Medical Examiners.
- (b) Certificate showing completion of one year of postgraduate medical training in a program acceptable to the Board.
- (c) Foreign medical graduates must submit proof of medical school curriculum meeting the requirements of the Washington Medical Practice Act, RCW 18.71.055.
- (d) Foreign medical graduates must provide their **original** standard E.C.F.M.G. certificate.
- (e) Two (2) letters of recommendation attached to this application.
- (f) See accompanying EXCERPTS for more detailed information.

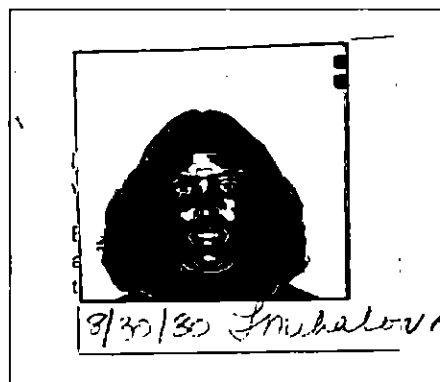
## 4. OSTEOPATHIC MEDICINE AND SURGERY ONLY

- (a) Copy of diploma issued by a legally chartered school of osteopathic medicine and surgery.
- (b) Certificate showing completion of one year of internship in any nationally accepted approved one year internship program; or the first year of a residency program approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations.
- (c) Two (2) letters of recommendation attached to this application.
- (d) See accompanying EXCERPTS for more detailed information.

5. IN ADDITION TO the requirements listed above, graduates of U.S. and Canadian medical schools and osteopathic schools must provide official transcripts direct from their school of graduation. Transcripts will NOT be accepted from the applicant.

## IDENTIFICATION

HEIGHT 5'6"	WEIGHT 160
COLOR OF EYES BROWN	COLOR OF HAIR BROWN



## PERSONAL DATA

If any of the following questions are answered "Yes", full details must be furnished on a separate (8 1/2 x 11 inch) sheet and attached to this application.

- |   | Yes                      | No                                  |
|---|--------------------------|-------------------------------------|
| 1. Have you ever been called before any state board for interrogation concerning any violation of the laws or rules pertaining to the profession for which you are applying or unethical conduct? ..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have you ever been convicted of a felony or misdemeanor other than traffic violations? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you ever been convicted of a violation of any state or federal Controlled Substances Act, or any drug or narcotic law? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you ever had a license to practice revoked or suspended? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you ever been addicted to or treated for addiction to any controlled substance? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you ever received psychiatric treatment or received treatment for a mental illness? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism? ....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Have you ever been denied the right to take an examination for licensing in any state? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Are you presently suffering from any disability or illness which could affect your ability to safely practice medicine? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. List any malpractice actions that have been filed against you, including the nature of the case, date and address of court where it is filed, and case status.                                      |                          |                                     |

# PREVIOUS REGISTRATION

Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current:

State or Other	Profession	Certificate		Permanent or Temporary	License Received By		Currently in Force
		Year	No.		Examination	Other	
WASHINGTON	MD	1980		TEMP	✓		

# PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience. Include college, university, medical or osteopathic school, and ALL periods of time from the date of graduation from medical or osteopathic school to the present whether or not engaged in activities related to medicine.

From Month, Day, Year	To Month, Day, Year	Name and Location of Institution, Place of Practice or Other	Degree or Certificate and Date Received, or Nature of Experience or Specialty
8/72	5/73	MACMURRAY COLLEGE; JACKSONVILLE, IL	—
9/73	6/74	NAT'L COLLEGE OF EDUCATION; EVANSTON, IL	—
8/74	5/76	UNIVERSITY of ILLINOIS; URBANA, IL	B.S. 6/76
8/76	6/80	UNIVERSITY of ILLINOIS COLLEGE of MEDICINE; CHICAGO, IL	M.D. 6/80
7/80	6/81	UNIVERSITY of WASHINGTON; SEATTLE, WA	FIRST YEAR RESIDENCY IN OBSTETRICS + GYNECOLOGY

Applicants for licensure by STATE RECIPROCITY must provide the following certification.

To be executed by the Secretary of the Board or Department of the State upon whose license the applicant relies for reciprocal registration in Washington. (To be completed only if license was obtained by written examination).

I certify that the aforesaid ..... in h..... examination before the

of this state attained a general average of ..... percent (or FLEX WEIGHTED AVERAGE OF ..... percent) and the following marks in the subjects named:

Subject	Percent	Subject	Percent

If FLEX examination please provide the following averages for each day.

DAY I ..... DAY II ..... DAY III .....  
BASIC SCIENCES ..... CLINICAL SCIENCES ..... CLINICAL COMPETENCE .....

I do further certify that a certificate to practice .....  
was issued to said applicant on the ..... day of ....., 19....., upon the following qualifications:

and said certificate has not been revoked or suspended and that, from the records now on file in this office, I believe h..... to be of good moral character and worthy of professional recognition, and recommend h..... to the Division of Professional Licensing of the State of Washington as a fit and proper person to receive recognition as an applicant for a reciprocity certificate permitting h..... to practice .....

In testimony thereof, witness my hand and seal this ..... day of ....., 19.....

[SEAL]

SECRETARY OF THE .....  
POST OFFICE ADDRESS .....

**AFFIDAVIT**

I, LINDA S. MIHALOV, being first duly sworn, depose and say that I am the person described and identified; that I am of good moral character; that I have not engaged in any of the acts prohibited by the statutes of the State of Washington; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentations.

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

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

Linda S. Mihalov, MD  
applicant's signature

Subscribed and sworn to before me this 28<sup>th</sup> day of AUGUST, 1981

Jean M. Allen  
Notary Public for the state of Washington  
Residing at Seattle

[SEAL]

MEDICAL BOARD WORKSHEET

NAME Linda S. Mihalov

DATE OF RECEIPT 9/1/81

DATE OF BIRTH 11/11/53

1. LICENSURE BY

a) National Board Waiver

84.9

b) Reciprocity from \_\_\_\_\_

c) FLEX Waiver

d) LMCC

e) Examination

2. FEE

\$75 Lim Lic.

3. ADDITIONAL PHOTOGRAPH

4. PROOF OF EDUCATIONAL EXPERIENCE

a) Medical School Diploma

12

b) Transcripts

Rec'd

c) Postgraduate Medical Training

d) Chronology

5. Personal Qualifications

6. FOREIGN GRADUATE

a) ECFMG

b) Medical School Subjects

7. LETTERS OF RECOMMENDATION

8. AFFIDAVIT

9. STATE CLEARANCE Mtd. \_\_\_\_\_

10. AMA CLEARANCE Mtd. 9/2/81

ADMINISTRATIVE RECOMMENDATION \_\_\_\_\_

BOARD ACTION

LICENSE

EXAM

APPROVED

DISAPPROVED

PENDING

DATE

9-23-81

REVIEWED BY

[Signature]

JOHN SPELLMAN  
Governor



JOHN GONSALEZ  
Director

STATE OF WASHINGTON  
DEPARTMENT OF LICENSING

September 10, 1981

Linda S. Mihalov, M.D.  
152 NE 53rd St.  
Seattle, Wa. 98105

Thank you for your medical application received in this office on 9-1-81. The next meeting of the Board will be on 11-6 & 11-7, 1981. Applications will be reviewed between Board meetings upon completion. Applications that need special Board consideration will be sent to the next Board meeting, if complete. Administrative requirements for processing applications take approximately 6-8 weeks after receipt of an application.

Your application lacks the following:

We have not received a certified copy of your Medical School Subjects.

COPIES OF ALL DOCUMENTS MUST BE CERTIFIED AS TRUE.

The address on the application will be on your medical license, unless otherwise notified.

Sincerely,

Chris Robert Rose  
Administrative Assistant  
Medical Section

~~Janet Walter~~  
Division of Professional Licensing  
P. O. Box 9649  
Olympia, WA 98504  
(206) 753-2205

MED 657-14  
(R/7/81)

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION  
535 NORTH DEARBORN STREET  
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES  
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 09-10-81  
TIME: 5:19 PM  
MEDICAL EDUCATION NUMBER: 01611801943  
98195

NAME: MIHALOV, LINDA S, M.D.  
ADDRESS: UNIV WASH AFFIL HOSPS-OBGYN SEATTLE WA  
BIRTHPLACE: BRIDGEPORT, CT BIRTHDATE: 11/11/53

MEDICAL EDUCATION (SCHOOL YEAR):  
UNIV OF ILLINOIS COLL MED, CHICAGO IL 60612  
NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE  
LICENSES:

1980

NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES:  
RESIDENT

PRIMARY SPECIALTY: OBSTETRICS AND GYNECOLOGY  
SECONDARY SPECIALTY: UNSPECIFIED  
TERTIARY SPECIALTY: UNSPECIFIED  
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

MEMBER OF AMA: NOT MEMBER  
NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE  
PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE  
CURRENT MEDICAL TRAINING: INTERN

HOSPITAL: UNIV WASH AFFIL HOSPS SEATTLE WA 98195  
DATES OF TRAINING: 07/80-06/81  
SPECIALTY: OBSTETRICS AND GYNECOLOGY  
SPECIALTY: UNSPECIFIED

INTERNSHIP:  
NONE REPORTED TO DATE  
RESIDENCY:  
NONE REPORTED TO DATE

COPYRIGHT 1981 AMERICAN MEDICAL ASSOCIATION \*\*AMA FILES CHECKED\*\* SEE REVERSE

**AMA PHYSICIAN PROFILE (CONTINUED)**

NO. 1000486 111 MEN BAOLEOMA  
 789171 MONROE HOSPITAL  
 01-02 ILLINOIS CHICAGO

210 OFFICE ATMA MAUVALE RO HOVIRVEE  
 210 OFFICE ATMA MAUVALE RO HOVIRVEE

1 101-10 10110

1 101-10 10110

1 1008.10 AMH H-1 DIACODE MENEM

IT IS MUTUALLY AGREED BETWEEN THE AMERICAN MEDICAL ASSOCIATION (AMA) AND THE REQUESTING ORGANIZATION THAT THIS PHYSICIAN PROFILE (SEE REVERSE) IS PROVIDED TO THE REQUESTING ORGANIZATION WITH THE UNDERSTANDING THAT (1) THE INFORMATION ON THE PROFILE WILL BE TREATED WITH TOTAL CONFIDENTIALITY; (2) THAT SUCH INFORMATION IS GRANTED SOLELY TO THE REQUESTING ORGANIZATION AND IS GRANTED AS A NON-EXCLUSIVE LIMITED LICENSE, CONSISTENT WITH AND LIMITED TO THE SPECIFIC PURPOSES SET FORTH ON THE PHYSICIAN PROFILE REQUEST FORM; (3) THAT NO PROFILE INFORMATION WILL BE RELEASED, COPIED, EXTRACTED OR OTHERWISE USURPED FOR THE USE BY ANY OTHER PARTY, ENTITY, ORGANIZATION OR GOVERNMENT AGENCY; AND (4) THAT UPON A BREACH OF ANY OF THE FOREGOING COVENANTS OR UPON THE EFFECTIVE DATE OF ANY STATUTE, REGULATION OR COURT DECISION MANDATING ANY DISCLOSURE WHATSOEVER OF SUCH PROFILE INFORMATION BY THE REQUESTING ORGANIZATION, SUCH LICENSE TO USE AND POSSESS THE PROFILE SHALL BE AUTOMATICALLY AND IMMEDIATELY TERMINATED AND THE PROFILE AND ANY INFORMATION OR DATA CONTAINED THEREON OR, IN ANY WAY, DERIVED THEREFROM SHALL BE RETURNED TO THE AMA IMMEDIATELY, BUT, IN NO EVENT, LATER THAN 48 HOURS AFTER SUCH AUTOMATIC TERMINATION.

OFFICE OF INFORMATION SERVICES

1000

DATE OF REPORT TO DATE

1000

DATE OF REPORT TO DATE

FOR THE PURPOSE OF THE PHYSICIAN PROFILE REQUEST FORM



AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION  
535 NORTH DEARBORN STREET  
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES  
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 09-16-81,  
TIME: 12:15 PM

NAME: MIHALOV, LINDA S, M.D.  
ADDRESS: UNIV WASH AFFIL HOSPS-OBGYN SEATTLE WA  
BIRTHPLACE: BRIDGEPORT, CT BIRTHDATE: 11/11/53

98195

MEDICAL EDUCATION (SCHOOL YEAR):

UNIV OF ILLINOIS COLL MED, CHICAGO IL 60612

1980

NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE

LICENSES:

NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES:

RESIDENT

PRIMARY SPECIALTY: OBSTETRICS AND GYNECOLOGY

SECONDARY SPECIALTY: UNSPECIFIED

TERTIARY SPECIALTY: UNSPECIFIED

SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

MEMBER OF AMA: NOT MEMBER

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

CURRENT MEDICAL TRAINING: INTERN

HOSPITAL: UNIV WASH AFFIL HOSPS SEATTLE WA

98195

DATES OF TRAINING: 07/80-06/81

SPECIALTY: OBSTETRICS AND GYNECOLOGY

SPECIALTY: UNSPECIFIED

INTERNSHIP:

NONE REPORTED TO DATE

RESIDENCY:

NONE REPORTED TO DATE

COPYRIGHT 1981 AMERICAN MEDICAL ASSOCIATION \*\*AMA FILES CHECKED\*\* SEE REVERSE

AMA PHYSICIAN PROFILE (CONTINUED)

IT IS MUTUALLY AGREED BETWEEN THE AMERICAN MEDICAL ASSOCIATION (AMA) AND THE REQUESTING ORGANIZATION THAT THIS PHYSICIAN PROFILE (SEE REVERSE) IS PROVIDED TO THE REQUESTING ORGANIZATION WITH THE UNDERSTANDING THAT (1) THE INFORMATION ON THE PROFILE WILL BE TREATED WITH TOTAL CONFIDENTIALITY; (2) THAT SUCH INFORMATION IS GRANTED SOLELY TO THE REQUESTING ORGANIZATION AND IS GRANTED AS A NON-EXCLUSIVE LIMITED LICENSE, CONSISTENT WITH AND LIMITED TO THE SPECIFIC PURPOSES SET FORTH ON THE PHYSICIAN PROFILE REQUEST FORM; (3) THAT NO PROFILE INFORMATION WILL BE RELEASED, COPIED, EXTRACTED OR OTHERWISE USURPED FOR THE USE BY ANY OTHER PARTY, ENTITY, ORGANIZATION OR GOVERNMENT AGENCY; AND (4) THAT UPON A BREACH OF ANY OF THE FOREGOING COVENANTS OR UPON THE EFFECTIVE DATE OF ANY STATUTE, REGULATION OR COURT DECISION MANDATING ANY DISCLOSURE WHATSOEVER OF SUCH PROFILE INFORMATION BY THE REQUESTING ORGANIZATION, SUCH LICENSE TO USE AND POSSESS THE PROFILE SHALL BE AUTOMATICALLY AND IMMEDIATELY TERMINATED AND THE PROFILE AND ANY INFORMATION OR DATA CONTAINED THEREON OR, IN ANY WAY, DERIVED THEREFROM SHALL BE RETURNED TO THE AMA IMMEDIATELY, BUT, IN NO EVENT, LATER THAN 48 HOURS AFTER SUCH AUTOMATIC TERMINATION.

SOCIAL SECURITY NUMBER <small>1 - DOH Licensee Social Sec...</small>		DATE ENTERED 9-20-76	COLLEGE MEDICINE	UNIVERSITY OF ILLINOIS at the MEDICAL CENTER - CHICAGO <b>RECEIVED</b> DEGREE AND DATE Doctor of Medicine SEP 14 1981 June 6, 1980 DIVISION OF PROFESSIONAL LICENSING
NAME AND ADDRESS Mihalov, Linda Sue 1140 Elizabeth Avenue Naperville, Illinois 60540				HIGH SCHOOL Naperville Central Naperville, Illinois 1972
CHANGE OF NAME TO:				
DATE OF BIRTH November 11, 1953	PLACE OF BIRTH Bridgeport, Connecticut			
ILLINOIS RESIDENCY <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	SEX <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	RESIDENCY	University of Washington Hospital Seattle, Washington	
COLLEGE(S) ATTENDED AND SEMESTER CREDITS EARNED MacMurray College - (36)      University of Illinois - Urbana - (69) National College of Education - (29)				
DEGREES B.S., University of Illinois-Urbana, May 1976				

MIHALOV, LINDA SUE

CERTIFYING EXAMINATIONS			
DATE		S	U
6-77	COMP EXAM I	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10-79	COMP EXAM II	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9-77	NATIONAL BOARD-Part I	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9-79	NATIONAL BOARD -Part II	<input checked="" type="checkbox"/>	<input type="checkbox"/>
_____	NATIONAL BOARD	<input type="checkbox"/>	<input type="checkbox"/>
_____	REPEAT	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>

DISCIPLINES INCLUDED IN COMP EXAM I—Anatomy (both gross and microscopic), Biochemistry, Physiology, Microbiology, Genetics, Behavioral Sciences, Pharmacology, and the Neurosciences.

DISCIPLINES INCLUDED IN COMP EXAM II—Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Psychiatry, Orthopedics, Dermatology, Preventive Medicine, and Community Health, plus elements of Pathology, Radiology, and Pharmacology woven throughout.

EVALUATION OF CLERKSHIP PERFORMANCE by clerkship supervisors is provided through a written description of the student's performance of appropriate motor tasks, his attitudes towards his supervisors, his peers, the patients, and health care team. Specific comments are encouraged regarding the student's willingness to accept professional responsibility, his curiosity, initiative, and ability to perform independently.

LAB SKILL PERFORMANCES			
DATE		S	U
6-77	Gross Anatomy	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6-77	Histology	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6-77	Microbiology	<input type="checkbox"/>	<input checked="" type="checkbox"/>
_____	REPEAT	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>

ELECTIVE EXPERIENCES **			
DATE	DATE		
MIHALOV, LINDA S <small>1 - DOH Licensee Social ...</small>			
03-26-79	04-21-79	OCCUP MEDICINE	*
04-23-79	05-19-79	FAMILY PRACTICE	*
07-16-79	08-11-79	DIAG RADIOLOGY	*
09-10-79	10-20-79	ENDOCRINOLOGY	*
11-05-79	11-24-79	CLIN DERMATOLOGY	*
11-26-79	12-22-79	FAMILY PRACTICE	*
02-25-80	03-22-80	NEPHROLOGY	*
03-24-80	05-17-80	CARDIOLOGY	*

CLINICAL CLERKSHIPS			
DATE	DATE		
MIHALOV, LINDA S <small>1 - DOH Licensee Soci...</small>			
09-12-77	11-19-77	PHARM PATH	*
11-28-77	12-17-77	HISTORY PHYSICAL	*
01-02-78	03-25-78	PROBLEM SOLVING	*
03-27-78	06-17-78	MEDICINE	S
07-17-78	09-30-78	SURGERY	S
10-02-78	11-25-78	PEDIATRICS	O
11-27-78	12-16-78	PSYCHIATRY	S
01-01-79	01-27-79	PSYCHIATRY	/
01-29-79	03-24-79	OB GYNE	C
05-21-79	06-16-79	OPHTH	S
06-18-79	07-14-79	ENT	S
01-28-80	02-23-80	ANESTH	S

\*\* ELECTIVES ARE NON-GRADED  
\* EVALUATION

HONORS:  
The Upjohn Award  
SEP - 3 1981

\* NON-GRADED PRECLINICAL EXPERIENCE

YEAR	PERIOD	STATUS	REMARKS
1ST YEAR	1976-77 (9-20-76/6-11-77)	SBMS - MC	Promoted to the second year.
2ND YEAR	1977-78 (6-20-77/6-10-78)	ALSM	Promoted to the third year.
3RD YEAR	1978-79 (6-19-78/6-9-79)	ALSM	Promoted to the fourth year.
4TH YEAR	1979-80 (6/18/79-6/6/80)	ALSM	

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS OF THE UNITED STATES OF AMERICA <b>Linda S. Mihalov, M.D.</b> having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners		<div style="font-size: 2em; font-weight: bold; text-align: center;">RECEIVED</div> SEP 1 1981 DIVISION OF PROFESSIONAL LICENSING
Attest: <b>WILLIAM B. HOLDEN</b> Chairman of the Board	SEAL	<b>EDITHE J. LEVIT</b> President of the Board
Philadelphia, Pa <b>07/01/81</b>	Cert. # <b>223728</b>	

Mihalov, L.S.

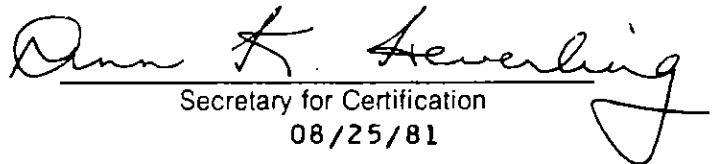
It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of **UNIVERSITY OF ILLINOIS** in **JUNE 1980**, whose birth date is **11/11/1953**, following successful completion of all examinations required for Certification by the National Board of Medical Examiners.

The grades obtained are as follows:

	Standard* Score	Scale Score
<u>PART I passed 09/77</u>		
Anatomy, incl. histology and embryology	585	86
Physiology	465	78
Biochemistry	580	86
Pathology	545	83
Microbiology, incl. immunology	565	85
Pharmacology and Materia Medica	625	88
Behavioral Sciences	595	87
<u>(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**</u>	575	84
<u>Part II passed 09/79</u>		
Internal medicine and the medical specialties	540	84
Surgery and the surgical specialties	610	88
Obstetrics and Gynecology	685	91
Public Health and Preventive Medicine	595	87
Pediatrics	590	87
Psychiatry	630	88
<u>(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**</u>	635	87
<u>PART III passed 03/81</u>		
A General Test of Clinical Competence		
<u>(Minimum Passing Grade 290/75)</u>	AVERAGE	545
		83.8
<u>GENERAL AVERAGE (Parts I, II, and III)</u>		84.9
		(Scale Score)

\*Examinations taken since June 1971 are reported with both Standard and Scale Score Equivalents.

\*\*Since 1966 National Board criteria for certification are based upon candidate's Total Grade in Part I, Part II, and Part III, and not scores of individual subjects within each Part.

  
 Secretary for Certification  
 08/25/81

SEAL



*By authority of the Board of Trustees of the*

# UNIVERSITY OF ILLINOIS

*and upon recommendation of the Senate  
at the Medical Center*

**Linda S. Mihalou**

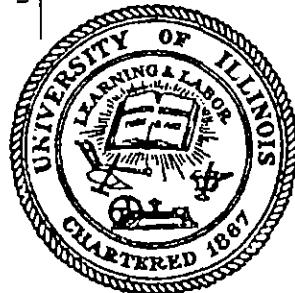
*has been admitted to the Degree of*

**Doctor of Medicine**

*and is entitled to all rights and honors thereto appertaining*

*Witness the Seal of the University and the signatures of its Officers*

*this sixth day of June, nineteen hundred and eighty.*



*W. D. [Signature]*

President of the Board of Trustees

*Carl W. [Signature]*

Secretary of the Board of Trustees

*Paul D. [Signature]*

President of the University

*Joseph S. [Signature]*

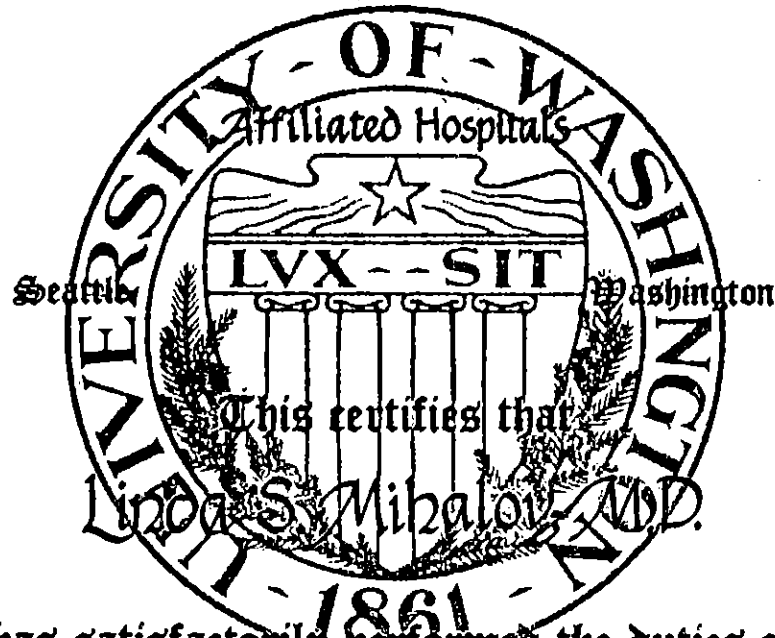
Chancellor

NOTARY PUBLIC for the State of Washington  
Residing at Seattle  
Commission Expires: 9/3/83

*[Handwritten Signature]*

# University of Washington

## School of Medicine



has satisfactorily performed the duties of

First Year Resident

July 1, 1980 to June 30, 1981

in witness whereof the undersigned affix their signatures

*Robert White*

Dean

*Marion G. Stenhouse*  
Chairman, Department of Obstetrics and Gynecology

NOTARY PUBLIC for the State of Washington  
Residing at Seattle.  
Commission Expires: 9/3/83

*Marion G. Stenhouse*

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING  
STATE OF WASHINGTON

This is to certify that I have known Linda Mihalev, M.D.  
for 1+ years, from 7-1-80 to present  
during which period she was engaged in the study or active practice  
of medicine. To the best of my knowledge she is of good moral  
and professional character, is free from habits which might inter-  
fere with her professional activities and is worthy of holding a  
license to practice Medicine in the State of  
Washington.

PLEASE PRINT OR TYPE

Name James R. Smith, M.D.  
Title Assoc. Prof. Ob-Gyn  
Capacity in which applicant known Resident in Ob-Gyn  
University of Washington (Attending Ob-Gyn)  
Address 1959 NE Pacific, Seattle, WA. 98195  
Licensed under laws of STATE OF WASHINGTON  
To practice Medicine (15877)

Please comment on applicant's professional character and ethics:

She has a very pleasant personality, deep  
concern for people & interests well. She is  
highly motivated, responsible, honest &  
maintains ethical standards. Performs  
well under stress. Excellent physician.

J. R. Smith, M.D.  
Signature

MED 657-12 LTR OF RECOMMENDATION  
(R/10/17/80)

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING  
STATE OF WASHINGTON

This is to certify that I have Known Linda Mihalov  
for 1 plus years, from 7-1-80 to current  
during which period she was engaged in the study or active practice  
of medicine. To the best of my knowledge she is of good moral  
and professional character, is free from habits which might inter-  
fere with her professional activities and is worthy of holding a  
license to practice Medicine and Surgery in the State of  
Washington.

PLEASE PRINT OR TYPE

Name Linda Mihalov, M. D.

Title Resident in Obstetrics and Gynecology

Capacity in which applicant known as above.

Harborview Medical Center  
Address 325-9th Avenue, Seattle, WA. 98104

Licensed under laws of Washington

To practice Medicine and Surgery

Please comment on applicant's professional character and ethics:  
Linda Mihalov is an exceptional young physician and surgeon who exhibits  
remarkable caring for her patients with her gentle application of her  
significant fund of knowledge and her increasing fine-tuned specialty  
skills. I have had the opportunity to observe her patient management  
and her interprofessional relationships closely in the past year  
and have never found her professional character and ethics ever  
questioned. It is my opinion that in this regard she well belongs  
in that highest category beyond reproach.

Edward Prince, MD

MED 657-12 LTR OF RECOMMENDATION  
(R/10/17/80)

Signature  
Edward Prince, M. D.  
Chief, Department of Obstetrics &  
Gynecology

EP/an

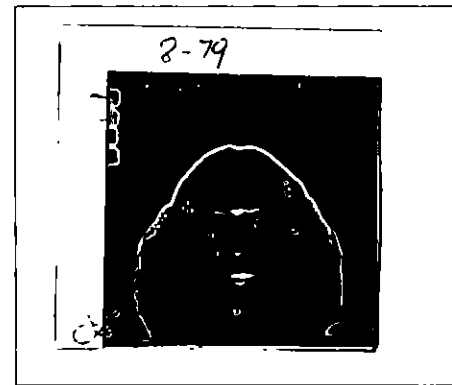
MIHALOV, LINDA MD\_00019539 PAGE 16





## IDENTIFICATION

HEIGHT 5'6"	WEIGHT 150
COLOR OF EYES BROWN	COLOR OF HAIR BROWN



## PERSONAL DATA

If any of the following questions are answered "Yes", full details must be furnished on a separate (8½ x 11 inch) sheet and attached to this application.

- |   | YES                      | NO                                  |
|---|--------------------------|-------------------------------------|
| 1. Have you ever been called before any state board for interrogation concerning any violation of the laws or rules pertaining to the profession for which you are applying or unethical conduct? ..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have you ever been convicted of a felony or misdemeanor other than traffic violations? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you ever been convicted of a violation of the Controlled Substance Act, or any narcotic law? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you ever had a license to practice revoked or suspended? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you ever been addicted to or treated for addiction to narcotic drugs? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you ever received psychiatric treatment or received treatment for a mental illness? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

## PREVIOUS LICENSURE

Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current:

STATE OR OTHER	PROFESSION	CERTIFICATE		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YEAR	NO.		EXAMINATION	OTHER	

## PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience including college, university, military, technical or professional school and practice pertaining to the profession for which you are making application. Include all periods of time from the date of graduation from medical school to the present whether or not engaged in activities related to medicine.

From ..... To Month, Day, Year	Name and Location of Institution, Place of Practice or Other	Degree or Certificate and Date Received, or Nature of Experience or Specialty
8/72 5/73	MACMURRAY COLLEGE JACKSONVILLE, IL	1 YR COLLEGE
9/73 6/74	NATIONAL COLLEGE OF EDUCATION EVANSTON, IL	1 YR COLLEGE
8/74 5/76	UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN, IL	B.S. - 5/76
8/76 present	UNIVERSITY OF ILLINOIS COLLEGE OF MED. CHICAGO, IL	M.D. - 6/6/80

AFFIDAVIT

I, LINDA S. MIHALOV, being first duly sworn, depose and say that I am the person  
print or type full name of applicant

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

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

this 9th day of April 19 80 Signature of applicant Linda S. Mihalov

Notary Public for Karen Lynn Dike

[Seal]

My commission expires: 3/31/81

MEDICAL BOARD WORKSHEET  
"LIMITED LICENSE"

NAME Linda S. Mihalov DATE OF RECEIPT 4-22-80

1. APPLICATION IN CONJUNCTION WITH:

- a) Institutions:  \_\_\_\_\_  
Name \_\_\_\_\_  
State license \_\_\_\_\_
- b) County-City Health Dept.:  \_\_\_\_\_  
Name \_\_\_\_\_  
State license \_\_\_\_\_
- c) Residency: Ob/gyn  \_\_\_\_\_  
Hospital Univ. of Washington

2. Fee:  \_\_\_\_\_

3. PROOF OF EDUCATIONAL EXPERIENCE:

- a) Medical School Diploma  UTR 6-23-80
- b) Verification of employment  \_\_\_\_\_
- c) Certification of postgraduate training  \_\_\_\_\_
- d) ECFMG  \_\_\_\_\_
- e) Chronology  \_\_\_\_\_

4. PERSONAL DATA:  \_\_\_\_\_

5. LETTERS OF RECOMMENDATION:  \_\_\_\_\_

6. AFFIDAVIT:  \_\_\_\_\_

7. STATE CLEARANCE: Mld.  \_\_\_\_\_

8. AMA CLEARANCE: Mld.  \_\_\_\_\_

ADMINISTRATIVE RECOMMENDATION: \_\_\_\_\_

	BOARD ACTION		
	LICENSE	EXAM	
APPROVED	<u>✓</u>	_____	DATE <u>4-29-80</u>
DISAPPROVED	_____	_____	<u>Redmond</u>

PENDING 3A REVIEWED BY \_\_\_\_\_

23 190



By authority of the Board of Trustees of the  
**UNIVERSITY OF ILLINOIS**

and upon recommendation of the Senate  
at the Medical Center

**Linda S. Mihalou**

has been admitted to the Degree of

**Doctor of Medicine**

and is entitled to all rights and honors thereto appertaining

Witness the Seal of the University and the signatures of its Officers  
this sixth day of June, nineteen hundred and eighty.



*W. D. ...*  
President of the Board of Trustees

*Earl W. ...*  
Secretary of the Board of Trustees

*Paul D. ...*  
President of the University

*Joseph S. ...*  
Chancellor

I certify that this is a true copy. Linda S. Mihalou, M.D.

STATE OF Washington }  
County of King } ss.

On this 17<sup>th</sup> day of June, A. D. 1980, before me, the undersigned, a Notary Public in and for the State of Washington, duly commissioned and sworn personally appeared Linda S. Mihalov, M.D.

to me known to be the individual described in and who executed the foregoing instrument, and acknowledged to me that she signed and sealed the said instrument as her free and voluntary act and deed for the uses and purposes therein mentioned.

WITNESS my hand and official seal hereto affixed the day and year in this certificate above written.

Gloua Jones  
Notary Public in and for the State of Washington  
residing at Auburn

(Acknowledgment by Individual. Washington Title Insurance Company. Form L 28)



University of Illinois at the Medical Center, Chicago

**THE ABRAHAM LINCOLN SCHOOL OF MEDICINE**

Office of the Dean

1853 West Polk Street, Chicago, Illinois 60612

(312) 996-2450

April 3, 1980

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

To Whom It May Concern:

Ms. Linda Mihalov, a senior student at the Abraham Lincoln School of Medicine at the University of Illinois College of Medicine, will have successfully met all the requirements for graduation by June 6, 1980. On this date, the degree of Doctor of Medicine will be conferred, and a diploma will be issued.

Sincerely,

*Kenneth L. Dike for*

*Gerard M. Cerchio*

Gerard M. Cerchio, M.D.  
Associate Dean  
Undergraduate Medical Education

GMC/nd

*Kenneth L. Dike*

*My Commission Expires 3/31/81*

Mihalov



STATE OF WASHINGTON  
Dixy Lee Ray  
Governor

DEPARTMENT OF LICENSING  
P.O. Box 9649, Olympia, Washington 98504

PROFESSIONAL LICENSING

MAR 26 1980

RECEIVED

This is to certify that Linda S. Mihalov, MD has been appointed as a resident\* in Obstetrics and Gynecology at the University of Washington Affiliated Service hospitals for the period beginning July 1, 1980. The individual  
Mo Day Yr

responsible for this resident's patient care activities will be Leon R. Spagoni, MD  
Director of Program  
(Signature)

\*Resident 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



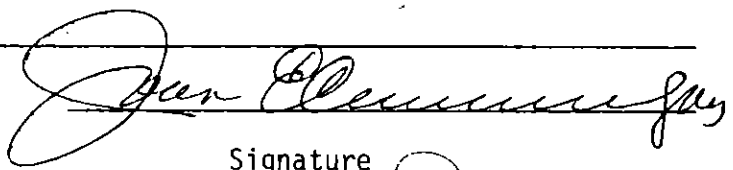
LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING  
STATE OF WASHINGTON

This is to certify that I have known LINDA MIHALOV  
for 3 years, from 1977 to 1980  
during which period She was engaged in the study or active practice of medicine.  
To the best of my knowledge She is of good moral and professional character, is  
free from habits which might interfere with her professional activities and is  
worthy of holding a license to practice Medicine in the  
State of Washington.

PLEASE PRINT OR TYPE

Name JOAN E. CUMMINGS M.D.  
Title SECTION CHIEF AMBULATORY CARE SERVICE  
Capacity in which applicant known AS SUPERVISOR IN  
MEDICAL SCHOOL CURRICULUM  
Address HINES V. A. Hosp. HINES, IL 60141  
Licensed under laws of Illinois - Lic # 36-43034  
To practice Medicine  
Remarks \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Signature

Kear Lynn Dike

M. J. ...

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING  
STATE OF WASHINGTON

This is to certify that I have known Linda Mihalov  
for 1 years, from 5/79 to 4/15/80  
during which period ~~she~~ she was engaged in the study ~~or active practice~~ of medicine.  
To the best of my knowledge ~~she~~ she is of good moral and professional character, is  
free from habits which might interfere with ~~her~~ her professional activities and is  
worthy of holding a license to practice medicine in the  
State of Washington.

PLEASE PRINT OR TYPE

Name Charles Kanakis, Jr., M.D.

Title Assistant Professor of Medicine

Capacity in which applicant known - STUDENT

Address 840 S. Wood St - Chicago, Illinois 60612

Licensed under laws of Illinois & California

To practice Medicine

Remarks \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Charles Kanakis, Jr.

Signature

Karen Lynn Orke  
Medical Director, Spokane 3/22/80



STATE OF  
WASHINGTON

Dixy Lee Ray  
Governor

DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

April 24, 1980

Linda S. Mihalov  
158 Harding St.  
Elgin, IL 60120

Dear Ms. Mihalov:

This is to advise that your application for limited medical license is complete for review by the Board of Medical Examiners.

However, before we can issue the license we must receive a notarized copy of your medical school diploma. Please send that document as soon as possible after your graduation. Your license will be processed and forwarded to the hospital where you will be serving your internship/residency within a few days after we have received that document.

If we can be of further assistance, you may contact this office.

Sincerely,

(Mrs.) Joanne Redmond  
Assistant Administrator  
Health Care Services

A handwritten signature in cursive script that reads "Nita Myers".

Nita Myers  
Limited License Section  
Professional Licensing Division  
(206) 753-2205

MED-657-62 L.L. Ack. Ltr.-111  
(N/2/80) wpc

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BILL (16) **7500** SIGN (42) SPLIT (43) QTRD (56)

NAME (17) **MIHALOV, LINDA S**

MAILING ADDRESSES (18-44-45)

**152 NE 53 RD ST**

CITY (46) **SEATTLE**

STATE (47) **WA** ZIP (48) **98105** CNTY (49) **17**

ADDITIONAL ADDRESSES (19-50-51)

1  
2  
3

CITY (52)

STATE (53) ZIP (54) CNTY (55)

RELATIONSHIP POINTER DATA

REV CODE (20) PIC/CIC (21)

NAME (22)

DOING BUSINESS AS (23)

1-30  
31-49

PHONE (25) SSN (26) TAX NO. (27)

EXAM DATE (28) LOCATION (29) CERT DATE (30) CERT NO. (31)

VOTER DISTRICT (32) TITLE (33) GRAD YR/SCH (34) **00430** LAST ISSUE DATE (35)

FIRST ISSUE DATE (37) BOND DATE (38) BOND TYPE (39) INS. DATE (40) INS. TYPE (41)

Redaction Summary ( 5 redactions )

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1 Privilege / Exemption reason used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" ( 5 instances )



Page 1, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance  
Page 11, DOH Licensee Social Security Number - RCW 42.56.350(1), 3 instances  
Page 17, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance