PHYSICIAN LICENSURE WORKSHEET

NAME: BARNETT, CLAIRE M				DOB: 12-13-61			
6-28-91	Application Received						Application Complete
✓	Fee Received	✓	Photo	✓	Affidavit	✓	AIDS
—	Personal Data Section Complete			Missing			
—	Yes Response to #____,____,____						Documentation Received
—	Chronology Complete			Missing Chronology to - to			
3/26	MDB	3/29	AMA		ECFMG		OTHER
LICENSURE MADE BY		FLEX	X	National Board		State Exam	LMCC
9/6/91	Scores Received						
MEDICAL SCHOOL	BROWN UNIV						
✓	US		Canada		Foreign		Offshore		Fifth Path
3/13	Transcripts Rcvd		Translations Rcvd	1988	Degree Rcvd		
POST GRADUATE TRAINING		1 Year	✓	2 Years			
X	MIRIAM 6/88 - 6/89						
7/5	SWEDISH 4/90 - 6/91						

STATE LICENSE VERIFICATION							
	✓						

HOSPITAL PRIVILEGES VERIFICATION			
8	MIRIAM HOSP	Residency	
	SWEDISH HOSP		

STAFF DECISION		
X	Approved: Beverly Bufford	Date: 9/10/91
	Further Review Required by Board:	Date:
BOARD DECISION		Date:
	Approved	Disapproved
BOARD COMMENTS		

4/18/91

Washington State Department of Health

PHYSICIAN & SURGEON

REVENUE SECTION

PRINT NAME Barnett, Claire

RETURN THIS PORTION
WITH CHECK & APPLICATION

MEDICAL EXAMINERS
JUL 03 1991
RCVD
1 025209 00238

002251 07/02/91 10000

LICENSING LOG

DATE	COMMENTS	NAME

STATE OF WASHINGTON
DEPARTMENT OF Licensing

MEDICAL EXAMINER'S
P.O. BOX 9649 OLYMPIA, WA 98504-8001
JUN 28 1991

FOR VALIDATION ONLY 02G-070-252-0009

APPLICATION FOR LICENSE TO RCVD

PRACTICE MEDICINE

MAKE REMITTANCE PAYABLE TO: STATE TREASURER

FOR OFFICE USE ONLY		
CERTIFICATE NO. 29037	ISSUE DATE 9-11-91	EXPIRATION DATE 12-13-91

APPLICATION FOR LICENSURE IS MADE BY: (check one)

- ☐ NATIONAL BOARD WAIVER
- ☐ ENDORSEMENT OF STATE EXAMINATION
- ☐ FLEX EXAMINATION WAIVER
- ☐ LMCC (must have been obtained after 1969)
- ☐ FLEX EXAMINATION

State _____ DATE OF EXAMINATION REQUESTED (month and year) _____

FOR OFFICE USE ONLY

PROG (1)	TRANS (3)	PROF CODE (4)	PIC/CIC (5)		EXPIRATION DATE (9)	EXPT (10)	STAT (11)	TYPE (12)
LA		252-09						

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

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME (20) BARNETT (LAST) CLAIRE (FIRST) MARGARET (MIDDLE)

ADDRESS (21) 1120 4th Ave. North

CITY (24) SEATTLE STATE (25) WA ZIP (26) 98109 COUNTY (27) KING

TELEPHONE NUMBER (39) 206-386-6000 - Page WHERE YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.

SOCIAL SECURITY NUMBER (40) 1 - DOH Licensee Social Security Numb... REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND IS NOT REQUIRED FOR LICENSING APPROVAL.

SEX (F or M) F BIRTHDATE 12 (MO.) 13 (DAY) 61 (YR.)

BIRTHPLACE WASHINGTON (CITY) DC (STATE) _____ (COUNTY)

MEDICAL SPECIALITY FAMILY PRACTICE

MEDICAL SCHOOL BROWN UNIVERSITY (NAME) USA (COUNTRY) YEAR GRADUATED 1988

FOR OFFICE USE ONLY	
EXAM DATE (42)	
VOTER DIST. (46)	
GRAD. YR./SCH. (48)	

HAVE YOU PREVIOUSLY APPLIED FOR A WASHINGTON STATE MEDICAL LICENSE OR LIMITED LICENSE? ☒ YES ☐ NO

LIST OTHER NAME(S) THAT APPEAR ON DOCUMENTS OR CREDENTIALS _____

FOLLOW CAREFULLY ALL INSTRUCTIONS IN GENERAL INSTRUCTIONS—ALL APPLICANTS. IT IS THE RESPONSIBILITY OF THE APPLICANT TO SUBMIT OR REQUEST TO HAVE SUBMITTED, ALL REQUIRED SUPPORTING DOCUMENTS.

IDENTIFICATION

HEIGHT	WEIGHT
5' 1"	125
COLOR OF EYES	COLOR OF HAIR
Brown	Auburn

PERSONAL DATA

	YES	NO
1. HAVE YOU EVER HAD A LICENSE TO PRACTICE MEDICINE SUSPENDED, REVOKED, RESTRICTED OR DENIED IN ANY STATE, FEDERAL OR FOREIGN JURISDICTION?	☐	☒
2. HAVE YOU EVER HAD HOSPITAL PRIVILEGES, OR MEDICAL SOCIETY MEMBERSHIP REVOKED, SUSPENDED OR RESTRICTED ON GROUNDS OF UNPROFESSIONAL CONDUCT, INCOMPETENCE, NEGLIGENCE, OR UNSAFE PRACTICES?	☐	☒
3. HAVE YOU EVER BEEN CONVICTED OF ANY GROSS MISDEMEANOR OR FELONY RELATING TO THE PRACTICE OF MEDICINE?	☐	☒
4. HAVE YOU EVER BEEN THE RECIPIENT OF ANY DISCIPLINARY ACTION, INCLUDING REPRIMAND OR HAVE YOU EVER ENTERED A STIPULATED AGREEMENT OR AGREED TO DISCONTINUE AN ACT ALLEGED AS A VIOLATION OF LAW OR AN UNSAFE PRACTICE?	☐	☒

IF RESPONSE TO 1, 2, 3, OR 4 IS AFFIRMATIVE, ATTACH CERTIFIED COPIES OF ORDERS, STIPULATIONS, AGREEMENTS, CHARGES, JUDGEMENTS, SENTENCE, FINDINGS AND NATURE OF DECISIONS. IF ON PAROLE OR PROBATION, INCLUDE A LETTER FROM THE SUPERVISING OFFICER INDICATING PROGRESS.

5. HAVE YOU EVER BEEN FOUND GUILTY OF THE VIOLATION OF ANY DRUG LAW, OR PRESCRIBING CONTROLLED SUBSTANCES FOR YOURSELF?	☐	☒
6. HAVE YOU EVER BEEN INVOLVED IN THE POSSESSION, USE, PRESCRIPTION FOR USE, OR DIVERSION OF CONTROLLED SUBSTANCES OR LEGEND DRUGS IN ANY OTHER THAN FOR LEGITIMATE OR THERAPEUTIC PURPOSES?	☐	☒
7. HAVE YOU EVER VOLUNTARILY SUBMITTED OR BEEN REQUIRED TO SUBMIT FOR TREATMENT FOR ALCOHOL DEPENDENCY?	☐	☒

IF RESPONSE TO 5, 6 OR 7 IS AFFIRMATIVE, ATTACH CERTIFIED COPIES OF CHARGES, SENTENCE, ORDER, STIPULATION AND/OR DISPOSITION. ALSO INCLUDE LETTERS FROM THE TREATING PROFESSIONAL AND/OR INSTITUTION STATING DETAILS OF CONDITION OR ADDICTION, TREATMENT AND PROGNOSIS.

8. HAVE YOU EVER RECEIVED TREATMENT FOR A MENTAL ILLNESS?	☐	☒
9. HAVE YOU EVER BEEN RELEASED FROM OR RESTRICTED IN A MEDICAL PROGRAM BECAUSE OF A MENTAL CONDITION OR ILLNESS?	☐	☒

IF RESPONSE TO 8 OR 9 IS AFFIRMATIVE, ATTACH CERTIFIED COPIES OF DIAGNOSIS, TREATMENT, OR PROGNOSIS ALONG WITH LETTERS FROM ANY TREATING PHYSICIAN AND/OR PROFESSIONAL STATING DETAILS OF CONDITION AND PROGNOSIS.

10. HAVE YOU EVER VOLUNTARILY GIVEN UP PRIVILEGES, A LICENSE TO PRACTICE, OR AGREED TO RESTRICT YOUR PRACTICE IN LIEU OF OR TO AVOID FORMAL ACTION? (IF YES, PROVIDE A NOTARIZED STATEMENT OF EXPLANATION)	☐	☒
11. HAVE YOU BEEN NAMED IN ANY MALPRACTICE SUITS ALLEGING YOUR INCOMPETENCE OR NEGLIGENCE IN THE PRACTICE OF MEDICINE? IF YES, INCLUDE THE NATURE OF THE CASE, DATE, AND SUMMARIZE CARE GIVEN. ENCLOSE A COPY OF THE ORIGINAL COMPLAINT AND SETTLEMENT OR FINAL DISPOSITION. IF PENDING, INDICATE THE STATUS.	☐	☒

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

EDUCATION AND EXPERIENCE

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY)

SCHOOLS ATTENDED—LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.	NUMBER OF YEARS ATTENDED	ATTENDANCE				DIPLOMA OR DEGREE OBTAINED QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH
		ENTRANCE		LEAVING		
		CLASS/ GRADE	DATE MO./YR.	CLS/GRD CMPLT.	DATE MO./YR.	
Medical Education (List all Medical Schools Attended)						
BROWN University	4	1	9/84	4	6/88	M.D.
Post-Graduate Training (List all programs attended)						
MIRIAM HOSPITAL (RI) INTERNAL MEDICINE	1	PG4-1	6/88	1	6/89	PG4-1
SWEDISH HOSPITAL FAM. PRACTICE - SEATTLE, WA	1+	PG4-2	4/90	continuing		

IN CHRONOLOGICAL ORDER LIST ALL PROFESSIONAL EXPERIENCE RECEIVED SINCE GRADUATION FROM MEDICAL SCHOOL TO THE PRESENT. (EXCLUDE ACTIVITIES LISTED UNDER OTHER SECTIONS.) (ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY)

INDICATE NATURE OF EXPERIENCE OR PRACTICE	INCLUSIVE DATES OF EXPERIENCE	
	BEGINNING MO./YR.	ENDING MO./YR.
PG4-1 - Internal Medicine Miriam Hosp. Providence RI	6/88	6/89
UNIV. OF NAIROBI, KENYATTA HOSP. NAIROBI, KENYA - Gen Medicine on Wards	7/89	4/90
PG4-2 → present Family Practice Residency - SWEDISH HOSP SEATTLE, WA	4/90	present

FIFTH PATHWAY

(ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY)

NAME AND LOCATION OF MEDICAL SCHOOL	NAME AND LOCATION OF HOSPITAL	INCLUSIVE DATES ATTENDED

PLEASE LIST HOSPITALS WHERE PRIVILEGES HAVE BEEN GRANTED WITHIN THE PAST FIVE (5) YEARS.

(FOR LOCUM TENENS, ENTER ONLY THOSE OF A 30 DAY OR LONGER DURATION. SEE INSTRUCTIONS REGARDING REPORTS AND VERIFICATION.) (ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY.)

MIRIAM HOSPITAL PROVIDENCE RI			
SWEDISH HOSPITAL SEATTLE, WA			

NOTE: IF ADDITIONAL 8½x11 SHEET(S) ATTACHED, PLEASE LABEL AS TO SUBJECT, i.e., FIFTH PATHWAY.

LICENSES IN OTHER STATES/COUNTRIES

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

STATE, COUNTRY OR PROVINCE	DATE LICENSE ISSUED	NUMBER	BASIS OF LICENSURE		STATUS OF LICENSE ACTIVE/INACTIVE	ANY LIMITATIONS ON LICENSE
			EXAMINATION (DATE PASSED)	ENDORSEMENT		

AFFIDAVIT

I, CLAIRE M. BARNETT, being first duly sworn, depose and say that
PRINT OR TYPE FULL NAME OF APPLICANT

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 documents presented in support of this application; that I am the lawful holder of a medical diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentations.

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

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

Applicant's Signature Claire M. Barnett

VAUGHN A. HOLDEN
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES SEPT. 19, 1993
(SEAL)

Subscribed and sworn to before me this 17th

day of JUNE, 1991

Vaughn A. Holden

Notary Public for the state of WASHINGTON

Residing at SEATTLE

STATE OF WASHINGTON
DEPARTMENT OF LICENSING
Highways-Licenses Building • Olympia, WA 98504 • (206) 753-6918

MEDICAL EXAMINER'S
JUN 28 1991
RCVD

CERTIFICATION OF COMPLETION
AIDS EDUCATION AND TRAINING

APPLICANT: Please complete the form below in full, attach a copy of the certificate of attendance and return to:

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

PLEASE PRINT OR TYPE
Applicant Name BARNETT (LAST) CLAIRE (FIRST) M. (MIDDLE)

Street Address 1120 4th Ave. N

City Seattle State WA ZIP 98109

Date of Birth 12 / 13 / 61

Profession for which I am now applying Family Practice Resident

I certify that I have received 4 hours of AIDS education and training through Swedish (ORGANIZATION, COLLEGE, UNIVERSITY, ETC.)
Residency on April 1990 (DATE)
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 psychosocial issues to include special population considerations, and have attached a certificate of attendance.

I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

C L Barnett (SIGNATURE) 4/8/91 (DATE)

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Claire Margaret Barnett, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest L. THOMPSON BOWLES, M.D., PH.D.
Chairman of the Board

SEAL ROBERT L. VOLLE, PH.D.
President of the Board

Philadelphia, Pa.
07/01/89

Certificate # 364956

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from BROWN U PROG IN MEDICINE in MAY 1988 and whose birth date is 12/13/1961. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/86		
Anatomy	415	75
Physiology	415	75
Biochemistry	440	77
Pathology	415	75
Microbiology	500	81
Pharmacology	470	79
Behavioral Sciences	550	84
TOTAL TEST (Minimum Passing Score 380/75)	445	77
PART II passed 09/87		
Medicine	485	81
Surgery	425	78
Obstetrics and Gynecology	505	82
Public Health and Preventive Medicine	560	85
Pediatrics	430	79
Psychiatry	510	83
TOTAL TEST (Minimum Passing Score 290/75)	485	81
PART III passed 03/89		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	455	80
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		79

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

MEDICAL EXAMINER'S
SEP 06 1991

Melanie Valente
Secretary for Certification

SEAL RCVD

08/27/91
Date

BROWN UNIVERSITY

THE MIRIAM HOSPITAL
164 SUMMIT AVENUE
PROVIDENCE, RHODE ISLAND 02906
(401) 331-8500 Ext.4035

Patient Care
Education
Research

FRED J. SCHIFFMAN, M.D.
ASSOCIATE PROFESSOR OF MEDICINE

ASSOCIATE PHYSICIAN-IN-CHIEF
DIRECTOR OF MEDICAL EDUCATION

February 21, 1990

Department of Medical Licensure
State of Washington
P.O. Box 9649
Olympia, Washington 98504-8001

Dear Sir:

This letter is being written in support of Dr. Claire Barnett who is applying for a medical license in the state of Washington.

I have known Claire for several years, having met her when she did her internal medicine rotation at this hospital.

She then came to us as an intern in June of 1988 and worked with us until June, 1989.

Claire is a rare and gifted young physician whose presence has been a source of edification and pleasure for everyone with whom she has had contact. She is a remarkably warm and articulate young woman who has a genuine interest in the well-being of her patients and her peers.

She is cogent and careful in her approach to clinical problems. She is organized and concise and efficient in the way she practices medicine. She knows how to prioritize, works hard and is a most effective clinician. She was sought after by medical students and colleagues because she is a good teacher and she is natural and gracious in her approach to the education of all around her.

She accepts criticism well, reads widely and deeply in areas where her knowledge is limited but is able to balance her time in a way that reveals a breadth of humanistic and family oriented concerns.

She is an extraordinarily good communicator, and does not limit her concerns to the medical problem at hand. She always considers preventive and public health issues as well as the broader family context in her approach to problems.

Her commitment to world health is real. She has spent time in Papua, New Guinea and will be spending a year working in a Pediatric AIDS hospital in Kenya before returning to her clinical training in Family Practice in the United States.

She is fully deserving of the superlatives I have used. In my role as faculty member at Yale University and my current position at Brown University, I have infrequently met an individual like Claire. She will grace any program lucky enough to recruit her.

If I can provide further information, please don't hesitate to contact me.

Sincerely,

Fred J. Schiffman, M.D.
Director of Medical Education

FJS:ema

disc#4

State of Rhode Island and Providence Plantations

№ 11639

DEPARTMENT OF HEALTH

Division of Professional Regulation

LIMITED MEDICAL REGISTRATION

This is to Certify that CLAIRE BARNETT, M.D.

is registered as a RESIDENT

in MIRIAM HOSPITAL

for the period ending 6/22/89 *under the provisions of Chapter 158 of the Public Laws of 1958. This limited registration entitles the above named to practice medicine only in the hospital or institution designated in accordance with the restriction specified in the above cited statute. This limited registration may be revoked at any time by this division.*

Date of Issue 6/9/88

Starting Date 6/23/88 Milton W. Hamolsky M.D.

Director

AND BROWN UNIVERSITY AFFILIATED HOSPITALS

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

Highways-Licenses Building • Olympia, WA 98504 • (206) 753 6918

MEDICAL EXAMINER'S
JUL 05 1991
RCVD

TO: Medical Post-Graduate Training Program Director
RE: Verification/Evaluation of Training

I am applying for a license to practice medicine in the State of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, directly to the address shown below. Thank you for your attention to this matter.

Claire Barnett, M.D.
Applicant (Please print or type)

12/13/61
(Birthdate)

Claire Barnett
Signature of Applicant

TO: Department of Licensing
Division of Professional Licensing
Health Care Licensing
P.O. Box 9649
Olympia, WA 98504

1. The above individual is or was engaged in post-graduate training in our program from 4/1/90 *Beginning Date* TO 6/30/91 *Ending Date*, In the field of Family Practice.

2. Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evauations conducted.) Met all expectations

3. Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? YES _____ NO X .If yes, please explain: _____

4. Is there anything in the participant's file which would indicate he/she would be unable to safely practice medicine? YES _____ NO X . If yes, please provide documentation.

5. We would appreciate any other documentation which you feel would assist us in the evaluation process.

Thank you.

NAME J M Scardefone MD
TITLE Director, Family Practice Residency
HOSPITAL Swedish Hospital Medical Center
(Please type or print)
ADDRESS 700 Minor Ave
Seattle WA 98104
DATE 6/30/91

MED 657 034 POST GRADUATE TRAINING (R/10/87)

Last Name	First Name	Middle Name	Degree Program	BROWN UNIVERSITY PROGRAM IN MEDICINE
BARNETT	CLAIRE	MARGARET	AB & MD	PROVIDENCE, RHODE ISLAND 02912

Date Of Birth
Place Of Birth
Sex F Student No. SISB04448
School Of Last Degree Candidacy

Degree	Date Awarded
DOCTOR OF MEDICINE	05/30/88

Inclusive Dates of Attendance	Level Of Degree	Date Awarded

MEDICAL EXAMINER'S RCVD MAR 13 1990

MAR 12 1990

Code	Course Number	Course title	Grade
	ADMITTED:		
	AS A FIRST TIME DEGREE CANDIDATE(09/06/83)		
	SEPTEMBER 1984 - DECEMBER 1984		
	BIOMED 117	MAMMALIAN PHYSIOLOGY	S
D	BIOMED 181	HUMAN MORPHOLOGY	S
	BIOMED 189	HUMAN HISTOLOGY	S
	BIOMED 390	SOCIAL BEHAVIORAL SCI	S*
	JANUARY 1985 - MAY 1985		
	BIOMED 128	BIOCHEM PHAMACOLOGY	S
	BIOMED 130	MEDICAL BIOCHEMISTRY	S
	BIOMED 158	MEDICAL MICROBIOLOGY	S
	BIOMED 184	GENERAL PATHOLOGY	S
	BIOMED 390	SOC & BEHAV SCIENCE	S*
	SEPTEMBER 1985 - DECEMBER 1985		
	BIOMED 361	NEUROSCIENCES	S*
H	BIOMED 364	NUTRITION	S*
	BIOMED 370	INTRO CLINICAL MED	S*
H	BIOMED 371	CARDIOLOGY	S*
H	BIOMED 373	NEPHROLOGY	S*
H	BIOMED 375	RESPIRATORY	S*
H	BIOMED 377	HEMATOLOGY	S*
	BIOMED 363A	CLINICAL PHARMACOLOGY	S*
	BIOMED 379A	SYSTEMIC PATHOLOGY	S*
	JANUARY 1986 - MAY 1986		
	BIOMED 362	NEUROSCIENCES	S*
	BIOMED 369	CLINICAL PSYCHIATRY	S*
	BIOMED 370	INTRO CLINICAL MEDICNE	S*
	BIOMED 372	IMS-ENDOCRINOLOGY	S*
	BIOMED 374	IMS-HUMAN GROWTH/DEV	S*
H	BIOMED 376	GASTROENTEROLOGY	S*
	BIOMED 363B	CLIN PHARMACOLOGY	S*
	BIOMED 378A	INFECTIOUS DISEASES	S*
	BIOMED 378B	SUPPORTING STRUCTURES	S*
	BIOMED 379B	SYSTEMIC PATHOLOGY	S*
	SEPTEMBER 1986 - DECEMBER 1986		
	REL ST 292	PREP OF THESES/DISSERT	A
	AUGUST 1986 - OCTOBER 1986		
12W	BIOMED 301	CLERKSHIP MEDICINE	S*
	NOVEMBER 1986 - JANUARY 1987		
12W	BIOMED 316	CLERKSHIP SURGERY	S*
	JANUARY 1987 - MAY 1987		
H	BIOMED 382	LABORATORY MEDICINE	S*
	FEBRUARY 1987 - APRIL 1987		
6W	BIOMED 346	PSYCHIATRY CLERKSHIP	S*
6W	BIOMED 381	COMMUNITY HEALTH	S*
	MAY 1987 - JULY 1987		
6W	BIOMED 331A	OBSTETRICS/GYNECOLOGY	S*
	MAY 1987 - JULY 1987		
6W	BIOMED 331B	PEDIATRICS CLERKSHIP	S*
	SEPTEMBER 1987 - DECEMBER 1987		
M	BIOMED 399A	AWAY ELECTIVE	S*
	AUGUST 1987 - OCTOBER 1987		
4W	BIOMED 303A	CL DERMATOLOGY	S*
2W	BIOMED 321A	CL OPHTHALMOLOGY	S*
	NOVEMBER 1987 - JANUARY 1988		
4W	BIOMED 306A	INFECTIOUS DISEASES	S*
4W	BIOMED 332A	PEDIATRIC HEMATOLOGY	S*
4W	BIOMED 392K	DIAGNOSTIC RADIOLOGY	S*
	JANUARY 1988 - MAY 1988		
M	BIOMED 304A	CLINICAL NEUROLOGY	S*
	FEBRUARY 1988 - APRIL 1988		
2W	BIOMED 318A	ORTHOPEDIC SURGERY	S*
2W	BIOMED 319B	PRNCPLE ANESTHESIOLOGY	S*
2W	BIOMED 327B	OTORHINOLARYNGOLOGY	S*
	DEGREE AWARDED(05/30/88)		

REMARKS:
08/87: BIOMED 399A, ELECTIVE CLERKSHIP
OUT-PATIENT PEDIATRICS - SEATTLE

Code Column

Enrolled
P Part-Time
O In Absentia

Academic Status
W Warning
S Serious Warning

Credit Values
A Audit Credit Only
H Half Credit
D Double Credit
T Triple Credit
Q Quadruple Credit
U Quintuple Credit
M Medical Credit Only
N Non-Credit
E Extra Credit Required For Graduate Credit
X Equivalent 6 Sem. Hrs. Practice Teaching
Z Equivalent 12 Sem. Hrs. Practice Teaching
W Weeks Of Medical Clerkship

Course Types
Y Year Course
R R.I. School Of Design
I Independent Study Internship

Grade Column

* Restricted to S/NC Option
# Temporary Grade (1st Half Year Course)

See Other Side For Grading System

Transcripts Not Valid Without Signature And Seal Of Registrar

Katherine P. Hall
REGISTRAR
Katherine P. Hall, Registrar

This Record Printed On 03/05/90

BACKGROUND IS IN BROWN, SIGNATURE IS IN RED

PAGE 1 OF 1

The attached information has been forwarded to you at the request of the student. The Family Educational Rights and Privacy Act of 1974 prohibits release of this information without the student's written consent. Please return this material to us if you are unable to comply with this condition of release.

Supplementary Information for Use in Evaluation of Transcripts

FRONT BACKGROUND IS IN BROWN, SIGNATURE IS IN RED

Official Transcript. An official transcript consists of a copy of the permanent record card, listing those courses for which a passing grade has been assigned. Courses from which a student withdraws or which are not completed satisfactorily are not entered on the permanent record.

Provision for other Material to be included with Transcripts. An undergraduate student may elect to include other materials with the official transcript as further information on academic work. The student provides this material and it is mailed with the transcript by the Registrar.

Grading System. The grading system described below became effective for undergraduates as of the beginning of the 1969-70 academic year and for graduate and medical students as of the beginning of the 1971-72 academic year.

All courses are graded, subject to the conditions noted in the following paragraphs, on one of the two following bases: (1) A,B,C/No Credit (NC), or (2) Satisfactory (S)/No Credit (NC). Beginning Semester I, 1974-75, an asterisk following a grade of S denotes that the choice of grade option for that course was not left to the student but was restricted to S/NC by the instructor. Although there is no minimum letter grade equivalent for Satisfactory (S), such an evaluation should be interpreted as comparable to the A,B,C/No Credit (NC) alternate system.

A minimum grade of either S or C in a 100- or 200- level course carries credit toward all advanced degrees; however, individual departments may, subject to approval of the Graduate Council, set higher grade requirements for specific advanced degree programs.

Grades used on grade reports and transcripts are as follows:

Passing Grades		
A, B, or C	INC OR I	Incomplete
S (Satisfactory)	ABS	Absent from final examination
S* (Satisfactory — restricted by instructor)	M	Missing. Grade not submitted at time report was prepared
	AUDIT	See paragraph below
	ED	Existing deficiency
	V	Invalid grade (S) for option selected

Academic Calendar. The normal academic year consists of two semesters of approximately fifteen weeks each.

Full-time and Part-time Enrollment. The normal full-time undergraduate course load is four courses per semester for eight semesters; however, a full-time student may elect to take three, four, or five courses in any given semester. Where course enrollment is not pertinent to the determination of full-time enrollment status (e.g., graduate students working on a thesis), such status is determined by the Dean. Permission of the Dean is required for part-time enrollment.

Unit of Credit. The unit of credit is the semester course. This is defined as one-fourth of a normal program of academic work for one semester (four courses) and, for purposes of evaluation, may be considered the equivalent of four semester hours of credit.

Course Numbering System. Courses numbered 1 to 99 are open to undergraduates. On occasion, however, and with approval of the student's department and the Dean, a graduate student may register for such a course with extra work for graduate credit, and this will be so noted. This provision does not apply to course level 1-99 taken for graduate credit by students in the Master of Medical Science program. Courses numbered 100 to 199 are open to undergraduates and graduate students. Courses numbered 200 and above are open to graduate students, and by special arrangement, to undergraduates. Courses numbered 300 and above are open only to students in the Program in Medicine.

Audits. Academic course credit is not granted for courses which are audited; however, an Audit is included on the permanent record only if the instructor concurs that the course work completed is acceptable as an Audit.

Degrees with Distinction. Baccalaureate degrees are awarded with one level of distinction only, magna cum laude, to approximately 20% of the graduating class.

FORM Rev 10 87

Office of the Registrar
Brown University

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
515 NORTH STATE STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF PHYSICIAN DATA SERVICES

RUN DATE: 03-22-91
TIME: 9:08 PM

NAME: BARNETT,CLAIRE M, M.D.
ADDRESS: THE MIRIAM HOSP-DEPT MED
PROVIDENCE RI 02906
BIRTHPLACE: WASHINGTON,DC
BIRTHDATE: 12/13/61
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL
BROWN UNIV PROGRAM IN MED, PROVIDENCE RI 02912
YEAR OF GRADUATION: 1988
LICENSES (INITIAL YEAR GRANTED BY STATE):
NONE REPORTED TO DATE
NATIONAL BOARD CERTIFICATION: 1989
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: RESIDENT
SELF DESIGNATED SPECIALTIES
PRIMARY: INTERNAL MEDICINE
SECONDARY: UNSPECIFIED
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: INTERN
HOSPITAL: MIRIAM HOSP PROVIDENCE RI 02906
DATES OF TRAINING: 07/88-06/89 -- (BEING RE-CONFIRMED)
SPECIALTY: INTERNAL MEDICINE
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: NONE REPORTED TO DATE
FELLOWSHIP: NONE REPORTED TO DATE

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

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

 ****AMA FILES CHECKED

04

AMA PHYSICAN 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.

RECEIVED
MAR 15 1991

TO THE APPLICANT

Complete the identifying information below and submit to:

Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102

Attention: Teresa Hubbard
Coordinator of Disciplinary Data Bank

- -

Department of Licensing
Health Care Licensing
1300 South Quince
Olympia, WA 98504

Date: 3/11/91

Dear Ms. Hubbard:

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

NAME: CLAIRE BARNETT

SSN #: 1 - DOH Licensee Social Security Number - RCW 42.56....

MEDICAL SCHOOL OF GRADUATION: BROWN UNIVERSITY - PROVIDENCE RI

YEAR OF GRADUATION: 1988

BIRTHDATE: 12·13·61

- -

RESPONSE:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAR 19 1991 RCVD

James R. Winn, M.D.

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

MEDICAL EXAMINER'S MAR 26 1991

KRISTINE M. GEBBIE
Secretary

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
BOARD OF MEDICAL EXAMINERS
1300 S.E. Quince St., MS: EY-25 • Olympia, Washington 98504 • (206) 753-2844

July 29, 1991

Claire M. Barnett
1120 4th avenue North
Seattle, WA 98109

Dear Dr. Barnett:

This is to acknowledge receipt of your application to practice medicine in the state of Washington. According to our records the following items have not been received in support of your application:

National Board Examination Scores
Postgraduate Training Verification/Evaluation:
Miriam 6/88 - 6/89
Hospital Privileges Verification:
Miriam Hospital
Swedish Hospital

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

If you have any questions, please contact me at (206) 753-2999.

Sincerely,

Mary Burgamy,
Program Representative

I told Sandra that this app. would go for review even though we are lacking verf. of $$.

I told her in the meantime she would need to get the #'s off of the back of the check.

I told her a # would not be issued if approved + no verf. of this money..

6/28/90 Kris

TO:

DATE TIME

FROM

OF

MESSAGE:

- ☐ Called You
- ☐ Returned Your Call
- ☐ Will Call Again
- ☐ Please Call
- ☐ Wants to See You
- ☐ Was Here To See You

SCAN NUMBER	Extension
OFF SCAN NUMBER (Area Code)	

SF 8023 3/87 -1261-

INITIALS

A Message For You

Claire Barnett - 25214

written June 14, 1990

#282586

cleared June 26

Sandra Twist - Swedish

TO:

DATE TIME

FROM

OF

MESSAGE:

- ☐ Called You
- ☐ Returned Your Call
- ☐ Will Call Again
- ☐ Please Call
- ☐ Wants to See You
- ☐ Was Here To See You

SCAN NUMBER	Extension
OFF SCAN NUMBER (Area Code)	

SF 8023 3/87 -1261-

INITIALS

A Message For You

MEDICAL BOARD WORKSHEET

"Limited License"

Name Barnett, Claire Margaret Date of Birth 12 (Month) 13 (Day) 61 (Year)

☐ FELLOWSHIP ~~Date $25~~ ☐ TEACHING/RESEARCH ☒ RESIDENCY

☒ FEE REC'D owe $25 ☒ PHOTO ☒ AFFIDAVIT

☒ PERSONAL DATA "Yes" response to #_____, _____, _____, _____

☒ CHRONOLOGY Missing_____ to_____

☒ MEDICAL SCHOOL TRANSCRIPTS

☒ VERIFICATION OF EMPLOYMENT (Dates) 4-4-90 to_____

☐ LETTER OF APPOINTMENT VERIFYING LICENSURE IN ANOTHER STATE

f/q ☐ STATE CLEARANCE RI, _____, _____, _____

☒ POST GRADUATE TRAINING ☑ Miriam Hosp, RI 7/88 - 7/89

☐ _____

☐ _____

☐ ECFMG

☑ AMA

☑ MDB

☑ AIDS AFFIDAVIT

☐ INSTITUTION_____

☐ STATE LICENSE_____

☐ COUNTY CITY HEALTH_____

☐ STATE LICENSE_____

Approved Patti Kathleen Disapproved_____ Date 6-30-90

MED 657-058 TD LIC. WORKSHEET (R/3/88)

STATE OF WASHINGTON

3083

BARNECM 391RL

DEPARTMENT OF LICENSING

P.O. BOX 9649 OLYMPIA, WA 98504-8001

FOR VALIDATION ONLY 026-070-252-0014

4001 000 050 042390 200.00

MEDICAL EXAMINER'S

APR 25 1990

RCVD

APPLICATION FOR

LIMITED LICENSE TO PRACTICE MEDICINE

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

☐ Institution ☐ County-City Health Dept. ☑ Internship-Residency

☐ Fellowship ☐ Teaching-Research

FOR OFFICE USE ONLY									
PROG (1)	TRANS (3)	PROF CODE (4)	PIC/CIC (5)		EXPIRATION DATE (9)		EXPT (10)	STAT (11)	TYPE (12)
LA		25214							
KEY DATE (13)	CLASS (14)	ASSN (15)	BILLED AMOUNT (16)		SIGN	SPLIT	QTRD		

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME (20) BARNETT (Last) CLAIRE (First) MARGARET (Middle)

ADDRESS (21) Swedish Hospital Family Practice Residency, 700 Minor Avenue

(INSTITUTION, MEDICAL SCHOOL, HOSPITAL, HEALTH DEPT.)

CITY (24) Seattle STATE (25) WA ZIP (26) 98104 COUNTY (27) King

APPLICANT'S TELEPHONE NO. (39) _____

(Enter the number at which you can be reached during normal business hours)

APPLICANT'S SOCIAL SECURITY NO. (40) 1 - DOH Licensee Social Security N...

(Requested for identification purposes only. Entering SSN is voluntary and is not mandatory for licensing approval.)

SEX (F or M) F DATE OF BIRTH 12 (Mo.) / 13 (Day) / 61 (Year)

OFFICE USE ONLY	
GRAD YR/SCH (48)	
CERT DATE (44)	
CERT NO (45)	

MEDICAL SPECIALTY Family Practice

INSTITUTION/HEALTH DEPT./MEDICAL SCHOOL/HOSPITAL:

(DBA-38) _____

INSTRUCTIONAL OR FELLOWSHIP PROGRAM: _____

MEDICAL SCHOOL ATTENDED: BROWN UNIV MEDICAL SCHOOL

YEAR OF GRADUATION 1988

FOLLOW CAREFULLY ALL INSTRUCTIONS IN GENERAL INSTRUCTIONS—ALL APPLICANTS. IT IS THE RESPONSIBILITY OF THE APPLICANT TO SUBMIT OR REQUEST TO HAVE SUBMITTED, ALL REQUIRED SUPPORTING DOCUMENTS.

IDENTIFICATION

HEIGHT	WEIGHT
5'1"	120 lbs
COLOR OF EYES	COLOR OF HAIR
Brown	Auburn

NOTICE TO APPLICANTS: ALL PERSONS LICENSED UNDER THIS SECTION SHALL BE SUBJECT TO THE JURISDICTION OF THE MEDICAL DISCIPLINARY BOARD TO THE SAME EXTENT AS OTHER MEMBERS OF THE MEDICAL PROFESSION, IN ACCORDANCE WITH CHAPTERS 18.72 AND 18.130 RCW.

PERSONAL DATA

	YES	NO
1. HAVE YOU EVER HAD A LICENSE TO PRACTICE MEDICINE SUSPENDED, REVOKED, RESTRICTED OR DENIED IN ANY STATE, FEDERAL OR FOREIGN JURISDICTION?	☐	☑
2. HAVE YOU EVER HAD HOSPITAL PRIVILEGES, OR MEDICAL SOCIETY MEMBERSHIP REVOKED, SUSPENDED OR RESTRICTED ON GROUNDS OF UNPROFESSIONAL CONDUCT, INCOMPETENCE, NEGLIGENCE, OR UNSAFE PRACTICES?	☐	☑
3. HAVE YOU EVER BEEN CONVICTED OF ANY GROSS MISDEMEANOR OR FELONY RELATING TO THE PRACTICE OF MEDICINE?	☐	☑
4. HAVE YOU EVER BEEN THE RECIPIENT OF ANY DISCIPLINARY ACTION, INCLUDING REPRIMAND OR HAVE YOU EVER ENTERED A STIPULATED AGREEMENT OR AGREED TO DISCONTINUE AN ACT ALLEGED AS A VIOLATION OF LAW OR AN UNSAFE PRACTICE?	☐	☑

IF RESPONSE TO 1, 2, 3, OR 4 IS AFFIRMATIVE, ATTACH CERTIFIED COPIES OF ORDERS, STIPULATIONS, AGREEMENTS, CHARGES, JUDGEMENTS, SENTENCE, FINDINGS AND NATURE OF DECISIONS. IF ON PAROLE OR PROBATION, INCLUDE A LETTER FROM THE SUPERVISING OFFICER INDICATING PROGRESS.

5. HAVE YOU EVER BEEN FOUND GUILTY OF THE VIOLATION OF ANY DRUG LAW, OR PRESCRIBING CONTROLLED SUBSTANCES FOR YOURSELF?	☐	☑
6. HAVE YOU EVER BEEN INVOLVED IN THE POSSESSION, USE, PRESCRIPTION FOR USE, OR DIVERSION OF CONTROLLED SUBSTANCES OR LEGEND DRUGS IN ANY OTHER THAN FOR LEGITIMATE OR THERAPEUTIC PURPOSES?	☐	☑
7. HAVE YOU EVER VOLUNTARILY SUBMITTED OR BEEN REQUIRED TO SUBMIT FOR TREATMENT FOR ALCOHOL DEPENDENCY?	☐	☑

IF RESPONSE TO 5, 6 OR 7 IS AFFIRMATIVE, ATTACH CERTIFIED COPIES OF CHARGES, SENTENCE, ORDER, STIPULATION AND/OR DISPOSITION. ALSO INCLUDE LETTERS FROM THE TREATING PROFESSIONAL AND/OR INSTITUTION STATING DETAILS OF CONDITION OR ADDICTION, TREATMENT AND PROGNOSIS.

8. HAVE YOU EVER RECEIVED TREATMENT FOR A MENTAL ILLNESS?	☐	☑
9. HAVE YOU EVER BEEN RELEASED FROM OR RESTRICTED IN A MEDICAL PROGRAM BECAUSE OF A MENTAL CONDITION OR ILLNESS?	☐	☑

IF RESPONSE TO 8 OR 9 IS AFFIRMATIVE, ATTACH CERTIFIED COPIES OF DIAGNOSIS, TREATMENT, OR PROGNOSIS ALONG WITH LETTERS FROM ANY TREATING PHYSICIAN AND/OR PROFESSIONAL STATING DETAILS OF CONDITION AND PROGNOSIS.

10. HAVE YOU EVER VOLUNTARILY GIVEN UP PRIVILEGES, A LICENSE TO PRACTICE, OR AGREED TO RESTRICT YOUR PRACTICE IN LIEU OF OR TO AVOID FORMAL ACTION? (IF YES, PROVIDE A NOTARIZED STATEMENT OF EXPLANATION)	☐	☑
11. HAVE YOU BEEN NAMED IN ANY MALPRACTICE SUITS ALLEGING YOUR INCOMPETENCE OR NEGLIGENCE IN THE PRACTICE OF MEDICINE? IF YES, INCLUDE THE NATURE OF THE CASE, DATE, AND SUMMARIZE CARE GIVEN. ENCLOSE A COPY OF THE ORIGINAL COMPLAINT AND SETTLEMENT OR FINAL DISPOSITION. IF PENDING, INDICATE THE STATUS.	☐	☑

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

EDUCATION

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

(ATTACH ADDITIONAL 8½ x 11 SHEET IF NECESSARY)

SCHOOLS ATTENDED—LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.	NUMBER OF YEARS ATTENDED	ATTENDANCE				DIPLOMA OR DEGREE OBTAINED QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH
		ENTRANCE		LEAVING		
		CLASS/ GRADE	DATE MO./YR.	CLS/GRD CMPLT.	DATE MO./YR.	
Medical Education (List all Medical Schools Attended)						
BROWN UNIV. MED. SCHOOL	4	1st yrs	Sept '84	4th yr	May '88	M.D.
Post-Graduate Training (List all programs attended)						
Miriam Hosp., RI	1	Intern	7/88	Intern	7/89	1st yr Residency - Int. Medicine

PREVIOUS LICENSURE

Specifically list licenses granted to practice medicine in location of applicant's origin.

STATE OR OTHER	PROFESSION	CERTIFICATE		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YEAR	NO.		EXAMINATION	OTHER	
Rhode Island	M.D	1988-1989		Temp		Part of residency	NO

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 school to the present whether or not engaged in activities related to medicine. (attach additonal 8½ x 11 sheet if necessary)

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
9/15/80	5/26/84	BROWN UNIV.	BA - SEMIOTICS 1984
9/3/84	5/23/88	BROWN UNIV MED. SCHOOL	MD 1988
5/23/88	6/23/88	VACATION	
6/23/88	~~7/1/89~~ 7/1/89	Internship at Miriam Hosp. Providence, RI	1st yr Residency - Int. Med 1989
7/1/89	8/1/89	VACATION	
8/1/89	4/1/90	KENYATTA NAT. HOSPITAL, Nairobi, KENYA	Exchange Physician w/ Univ of Nairobi Dept of Med

PLEASE LIST HOSPITALS WHERE PRIVILEGES HAVE BEEN GRANTED WITHIN THE PAST FIVE (5) YEARS.

(FOR LOCUM TENENS, ENTER ONLY THOSE OF A 30 DAY OR LONGER DURATION. SEE INSTRUCTIONS REGARDING REPORTS AND VERIFICATION.) (ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY.)			

NOTE: IF ADDITIONAL 8½x11 SHEET(S) ATTACHED, PLEASE LABEL AS TO SUBJECT, i.e., FIFTH PATHWAY.

AFFIDAVIT

I, CLAIRE M. BARNETT, being first duly sworn, depose and say that
PRINT OR TYPE FULL NAME OF APPLICANT

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 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

Signature of applicant C M Barnett

VAUGHN A. HOLDEN NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES SEPT. 19, 1993

Subscribed and sworn to before me

this 13TH day of APRIL, 19 90

Vaughn A. Holden

Notary Public for STATE OF WASHINGTON

My commission expires: 9-19-93

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

This is to certify that Claire Barnett, M.D. has been appointed as a resident* in Family Practice Service at the Swedish Hospital Medical Center hospital for the period beginning April 4, 1990 (Mo Day Year). The individual responsible for this resident's patient care activities will be

[signature] M.D.

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

MED-657-57
(R/01/78)

A

VENDOR NO.	SWEDISH HOSPITAL MEDICAL CENTER	CODE	CHECK NO.
S017000000	Seattle, W[redacted]104-2196	02-ATT	277073

VENDOR NAME		DATE	PAGE
STATE OF WASHINGTON	0101	04/19/90	1

DATE	INVOICE NO.	VOUCHER	GROSS	DISCOUNT	NET
04/06/90	BARNETT/FEE	2510008064	200.00	.00	200.00
	RE:CLAIRE BARNETT,MD				
	LIMITED LICENSE APPLICATION				
	FEE				
	* TOTAL *		200.00	.00	200.00

B-147C REV 12/89
STOCK NO. 5750

DETACH VOUCHER BEFORE DEPOSITING

BARNETT, CLAIRE MD, 00020027 AND ML, 20003089 PAGE 21

MEDICAL EXAMINER
- JUL 06 1990
RCVD

at review Lmt

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

Department of Health
JUL 06 1990
Licensing and Certification
Assistant Secretary

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF PHYSICIAN DATA SERVICES

DATE: 06-29-90
TIME: 9:04 PM

NAME: BARNETT,CLAIRE M, M.D.
ADDRESS: THE MIRIAM HOSP-DEPT MED
PROVIDENCE RI 02906
BIRTHPLACE: WASHINGTON,DC
BIRTHDATE: 12/13/61
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL
BROWN UNIV PROGRAM IN MED, PROVIDENCE RI 02912
YEAR OF GRADUATION: 1988
LICENSES (INITIAL YEAR GRANTED BY STATE):
NONE REPORTED TO DATE
NATIONAL BOARD CERTIFICATION: 1989
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: RESIDENT
SELF DESIGNATED SPECIALTIES
PRIMARY: INTERNAL MEDICINE
SECONDARY: UNSPECIFIED
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: INTERN
HOSPITAL: MIRIAM HOSP PROVIDENCE RI 02906
DATES OF TRAINING: 07/88-06/89 -- (CONFIRMED)
SPECIALTY: INTERNAL MEDICINE
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: NONE REPORTED TO DATE
FELLOWSHIP: NONE REPORTED TO DATE

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

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

 ****AMA FILES CHECKED

09

AMA PHYSICAN 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.

Per your request to update the AMA Physician Profile for the attached, PLEASE NOTE:

_____ A New Profile reflecting these changes is enclosed.

_____ As of this date, the changes could not be verified.

_____ The information the AMA had on this Physician was correct.

__X__ Other explanation:

We have changed the doctors birthplace.

If you have further questions, please contact Wayne Pionke, 312) 645-5138.

DR-146b
6/88

SWEDISH HOSPITAL MEDICAL CENTER
AUTHORIZATION FOR PAYMENT

6/4/90
Date

TO State of Washington
Dept of Licensing
P.O. Box 9649
Olympia, WA 98504-8001

EXAMINED

APPROVED

ITEM	DESCRIPTION	DETAIL	AMOUNT	
	Re: Additional Impaired Physician License Fees @$25 each for the following: Claire Barnett, M.D. Jeffrey Young Charlotte Clark-Neitzel, M.D. Craig Davidson Pamela Parker Robert Klem Keith Hurst Robert Stonecipher		$ 200.00	
DEBIT	8240			

CHECK NO.

RECEIVED

B-135 Bus. Off. 4/75 FC/TSHMC SN-5981

4109 000 050 062290 200.00

MEDICAL EXAMINER'S
JUN 26 1990
RCVD

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

Highways-Licenses Building • Olympia, WA 98504 • (206) 753-6918

MEDICAL EXAMINER
MAY 30 1990
RCVD

Department of Health
MAY 30 1990
Licensing and Certification
Asst. Secretary

CERTIFICATION OF COMPLETION
AIDS EDUCATION AND TRAINING

APPLICANT: Please complete the form below in full, attach a copy of the certificate of attendance and return to:

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

PLEASE PRINT OR TYPE

Applicant Name BARNETT (LAST) CLAIRE (FIRST) M (MIDDLE)

Street Address 700 Minor Ave. Family Practice Clinic

City Seattle State WA ZIP 98104

Date of Birth 12 / 13 / 61

Profession for which I am now applying Family Practice Residency

I certify that I have received ~~4 hours~~ extensive of AIDS education and training through Medical School (ORGANIZATION, COLLEGE, UNIVERSITY, ETC.)

at Brown + 1 yr residency at Miriam Hospital RI on 1988 – 1989 (DATE)

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 psychosocial issues to include special population considerations, and have attached a certificate of attendance.

I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

C L Barnett
SIGNATURE

May 24, 1990
DATE

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

D E P A R T M E N T O F H E A L T H

12 June 1990

State of Washington
Department of Licensing
P.O. BOX 9649
Olympia WA 98504

To Whom it May Concern:

This is to certify that Claire Barnett was granted a Limited Medical License # 11639 for the period of one year from 23 June 1988 through 22 June 1989, based upon her appointment as a Resident in training at the Miriam Hospital. During that period of time there were no unfavorable entries. in her record.

Sincerely,

Milton W. Hamolsky MD

Milton W. Hamolsky, M.D.
Chief Administrative Officer
BOARD OF MEDICAL LICENSURE
AND DISCIPLINE

MWH:lcd

BARNETT

TO THE APPLICANT

Complete the identifying information below and submit to:

Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102

Attention: Teresa Hubbard
Coordinator of Disciplinary Data Bank

- -

Department of Health
Board of Medical Examiners
P.O. Box 1099
Olympia, WA 98507-1099

Date: 5-24-90

Dear Ms. Hubbard:

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

NAME: Claire Margaret Barnett

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

04301 **MEDICAL SCHOOL OF GRADUATION:** Brown Univ Med School

YEAR OF GRADUATION: 1988

BIRTHDATE: 12-13-61

- -

RESPONSE:

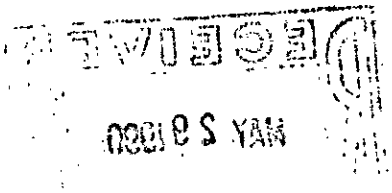
WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

MAY 30 1990

James R. Winn, M.D.

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

DOH-657-072 MEDICAL DISCIPLINARY REQUEST (R/11/89)




JUN 1990

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF PHYSICIAN DATA SERVICES

DATE: 05-31-90
TIME: 11:38 PM

NAME: BARNETT,CLAIRE M, M.D.
ADDRESS: THE MIRIAM HOSP-DEPT MED
PROVIDENCE RI 02906

MEDICAL EXAMINER'S
JUN 5 1990
RCVD

BIRTHPLACE: CA,
BIRTHDATE: 12/13/61
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL
BROWN UNIV PROGRAM IN MED, PROVIDENCE RI 02912
YEAR OF GRADUATION: 1988
LICENSES (INITIAL YEAR GRANTED BY STATE):
NONE REPORTED TO DATE
NATIONAL BOARD CERTIFICATION: 1989
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: RESIDENT
SELF DESIGNATED SPECIALTIES
PRIMARY: INTERNAL MEDICINE
SECONDARY: UNSPECIFIED
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: INTERN
HOSPITAL: MIRIAM HOSP PROVIDENCE RI 02906
DATES OF TRAINING: 07/88-06/89 -- (CONFIRMED)
SPECIALTY: INTERNAL MEDICINE
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: NONE REPORTED TO DATE
FELLOWSHIP: NONE REPORTED TO DATE

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

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

 ****AMA FILES CHECKED

09

AMA PHYSICAN 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.

Application File_436839_pdf-r.pdf redacted on: 12/8/2014 08:51

Redaction Summary (4 redactions)

1 Privilege / Exemption reason used:

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

Page 5, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 19, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 26, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 38, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance