APPLICATION FOR
18862
(Check one)
1/8/81

LICENSE TO PRACTICE

☒ **MEDICINE**

☐ **OSTEOPATHY AND SURGERY**

JUN 22-79 B 8421 [illegible] 50.00

MONEY CTL.

lic & ltr mld 1/9/81

FEES
Medicine with Exam $125.00
Medicine w/o Exam ..... $ 75.00
Osteopathy & Surgery ..... $ 75.00

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 $50.00

Application for licensure is made by: (Check one)

☒ National Board waiver.
☐ Reciprocity from (state) _____
☐ Examination. (FLEX)
☐ L. M. C. C.
☐ Flex waiver.

RECEIVED
JUN 22 1979
DIVISION OF
ESSIONAL LICENSING

WE-LC-HP-D516JE 0 00-00-00
WELCH,PHILIP DAVID

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

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME WELCH (Last) PHILIP (First) DAVID (Middle)

ADDRESS 2107 E. MERCER

CITY SEATTLE STATE WA ZIP 98112 COUNTY KING

TELEPHONE NO. 322-4895
Enter the number at which you can be reached during normal business hours.

SOCIAL SECURITY NUMBER _____
1 - DOH Licensee Social Security Number - RC...
Requested for identification purposes only. Entering SSN is voluntary and is not required for licensing approval.

SEX (For M) M DATE OF BIRTH 4 (mo.) 5 (day) 49 (yr.)

BIRTHPLACE HARTFORD (City) CT (State) _____ (County)

MEDICAL SPECIALTY OB-GYN

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

ARE YOU A U.S. CITIZEN? ☒ YES ☐ NO
IF NOT, ARE YOU A RESIDENT ALIEN? ☐ YES ☐ NO

U. of Wash. - 1978

INSTRUCTIONS

1. ALL APPLICANTS
   (a) This application and supporting documents, should be filed with the Division of Professional Licensing at least forty-five (45) 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 (8½ 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.

PREVIOUS REGISTRATION

Welch, P. D.

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	
WASH	MED	78		TEMP			YES

RECEIVED
SEP 16 1980
DIVISION OF
PROFESSIONAL LICENSING

PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience including college, university, medical school, osteopathic school, post-graduate training, internships, residencies and practice. Include **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
6/78	6/79	SWEDISH HOSP, SEATTLE, WA	INTERNSHIP
9/67	1/69	YALE UNIV	UNDERGRAD
1/69	9/71	INDEPENDENT EMPLOYMENT	
9/71	6/74	U OF W - PRE-MED	BS - ZOOLOGY
9/74	6/78	UW SCH OF MEDICINE	MD
7/6/78	6/79	INTERNSHIP SWEDISH HOSP, SEATTLE	SURGERY, FLEXIBLE
7/79	6/80	RESIDENCY, U OF W, R2	OB-GYN, CATEGORICAL

APPLICANTS MUST PROVIDE THE FOLLOWING

2. 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.

3. OSTEOPATHY AND SURGERY ONLY
   (a) Copy of diploma issued by a legally chartered school of osteopathy and surgery.
   (b) Certificate showing completion of one year of internship in an approved hospital having at least 25 beds for each intern.
   (c) Evidence of at least six weeks in the maternity department with attendance upon not less than six confinements.
   (d) Evidence of experience in and practical working knowledge of pathology, and the administering of internal medicine and drugs including anaesthetics.
   (e) Two (2) letters of recommendation attached to this application.
   (f) See accompanying EXCERPTS for more detailed information.

IDENTIFICATION

HEIGHT	WEIGHT
5' 11"	191
COLOR OF EYES	COLOR OF HAIR
Br	Br

Philip Welch, M.D.

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?	☐	☐
2. Have you ever been convicted of a felony or misdemeanor other than traffic violations?	☐	☐
3. Have you ever been convicted of a violation of the Controlled Substances Act, or any narcotic law?	☐	☐
4. Have you ever had a license to practice revoked or suspended?	☐	☐
5. Have you ever been addicted to or treated for addiction to narcotic drugs?	☐	☐
6. Have you ever received psychiatric treatment or received treatment for a mental illness?	☐	☐
7. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism?	☐	☐
8. Have you ever been denied the right to take an examination for licensing in any state?	☐	☐

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	
WASH	MED	78		TEMP			YES

PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience including college, university, medical school, osteopathic school, post-graduate training, internships, residencies and practice. Include **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 ..... 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
6/78	6/79	SWEDISH HOSP, SEATTLE, WA	INTERNSHIP

CERTIFICATION

Applicants for licensure by NATIONAL BOARD WAIVER must furnish "Certification of Record" direct from National Board.

Applicants for licensure by FLEX WAIVER must furnish examination results direct from the FLEX office, 1612 Summit Avenue, Fort Worth, Texas 76102.

Applicants for licensure by STATE RECIPROCITY or L.M.C.C. 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.

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 BASIC SCIENCES ..... DAY II CLINICAL SCIENCES ..... DAY III 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, ... (print or type full name of applicant), 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 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.

Philip Welch MD
..... (applicant's signature)

Subscribed and sworn to before me this 13TH day of JUNE, 19 79

Vaughn A. Holden
.....

[SEAL]

Notary Public for the state of WASHINGTON

SEATTLE

I 6886 70 041178 ✓40.
6234

MONEY CTL

APPLICATION FOR 8-25-78 6-30-79
ID # 159 LH

LIMITED LICENSE TO PRACTICE MEDICINE

FEE **$40.00**
(Includes $25.00 application fee and $15.00 License Issuance fee.)

DIVISION OF PROFESSIONAL LICENSING
P. O. BOX 649
OLYMPIA, WA. 98504

RECEIVED
APR 1978
DIVISION OF PROFESSIONAL LICENSING

Make remittance payable to: STATE TREASURER

Limited license application is made in conjunction with employment in: (Check one)
☐ Institutions ☐ County-City Health Dept. ☒ Residency/Internship

FOR OFFICE USE ONLY

PROG	TRANS	PROF CODE	PIC/CIC	EXPIRATION DATE	EXPT	STAT	TYPE
LA		25214	WE-LC-HP-D516JE 0 00-00-00				
KEY DATE		CLASS	WELCH,PHILIP DAVID	SIGN	SPLIT	QTRD	

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME Welch (Last) Philip (First) David (Middle)

ADDRESS Swedish Hospital Medical Center, 747 Summit Avenue

CITY Seattle STATE WA ZIP 98104 COUNTY King

EMPLOYER'S NAME (DBA) The Swedish Hospital Medical Center

APPLICANT'S TELEPHONE NO. 206-292-2265
Enter the number at which you can be reached during normal business hours.

APPLICANT'S SOCIAL SECURITY NO. _____
Requested for identification purposes only. Entering SSN is voluntary and is not required for licensing approval.

APPLICANT'S SEX (F or M) M DATE OF BIRTH 4/5/49 (mo. day yr.)

PLACE OF BIRTH Hartford, Connecticut

ARE YOU A U.S. CITIZEN? ☒ YES ☐ NO
IF NOT, ARE YOU A RESIDENT ALIEN? ☐ YES ☐ NO

OFFICE USE ONLY
GRAD YR/SCH ____

MEDICAL SPECIALTY _____

APPLICANT'S RESIDENCE ADDRESS 2107 E. MERCER ST.

CITY SEATTLE STATE WA ZIP 98112 COUNTY _____

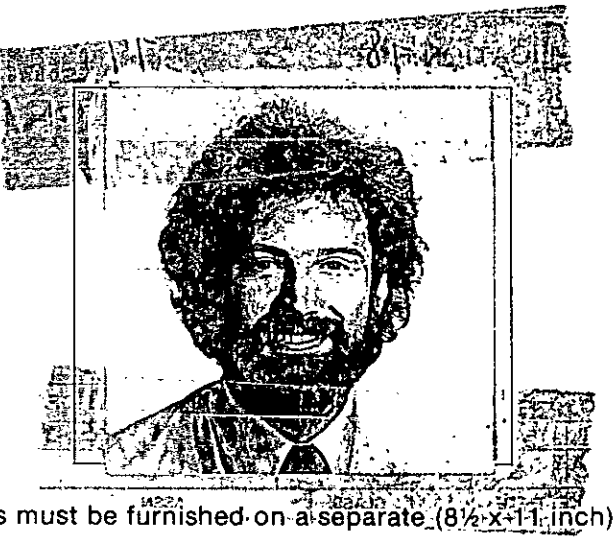
INSTRUCTIONS

1. This application, together with supporting documents and fee should be filed with the Division of Professional Licensing not later than forty-five (45) days prior to the Board meeting at which it is to be reviewed.
2. If additional space is required, attach separate (8½ x 11 inch) sheets, indicating the section to which they refer.
3. Attach a certified copy of Medical School diploma.
4. Attach a certified copy of one year of postgraduate training. (If appropriate)
5. Attach a certification of licensure status from another state (If appropriate)
6. If a foreign medical graduate, attach evidence of completion of E.C.F.M.G.
7. Two (2) Letters of recommendation attached to this application.

COPIES OF ALL DOCUMENTS MUST BE CERTIFIED AS TRUE AND NOTARIZED.
FEE MUST ACCOMPANY APPLICATION.

3-14-78

IDENTIFICATION



HEIGHT	WEIGHT
5' 11"	150
COLOR OF EYES	COLOR OF HAIR
BROWN	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?	☐	☒
2. Have you ever been convicted of a felony or misdemeanor other than traffic violations?	☐	☒
3. Have you ever been convicted of a violation of the Controlled Substance Act, or any narcotic law?	☐	☒
4. Have you ever had a license to practice revoked or suspended?	☐	☒
5. Have you ever been addicted to or treated for addiction to narcotic drugs?	☐	☒
6. Have you ever received psychiatric treatment or received treatment for a mental illness?	☐	☒
7. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism?	☐	☒

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
9-67	1-69	YALE UNIV	UNDERGRADUATE
9-71	3-74	UNIV. OF WA.	BS ZOOLOGY
9-74	3-78	U. OF W. SCHOOL OF MEDICINE	MD

AFFIDAVIT

I, PHILIP D. WELCH, 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 penaly 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 28 day of MARCH 19 78 Signature of applicant Philip D Welch

Vaughn A. Holden

[Seal]

Notary Public for WASHINGTON

My commission expires: 9-16-81

MEDICAL BOARD WORKSHEET
"LIMITED LICENSE"

NAME WELCH, PHILIP DAVID DATE OF RECEIPT April 11, 1978

1. APPLICATION IN CONJUNCTION WITH:

a) Institutions: ☐

Name

State license

b) County-City Health Dept.: ☐

Name

State license

c) ✓ Residency: Swedish ☑

Hospital Hospital

2. Fee: ☑

3. PROOF OF EDUCATIONAL EXPERIENCE:

a) Medical School Diploma ☒ NR Rcd 8-3-78

b) Verification of employment ☑

c) Certification of postgraduate training ☐

d) ECFMG ☑ Requested

e) Chronology ☑

4. PERSONAL DATA: ☑

5. LETTERS OF RECOMMENDATION: ☑

6. AFFIDAVIT: ☑

7. STATE CLEARANCE: Mld. ☐

8. AMA CLEARANCE: Mld. 04-11-78 ☑

ADMINISTRATIVE RECOMMENDATION: ok

BOARD ACTION

	LICENSE	EXAM
APPROVED		
DISAPPROVED		

DATE 8/3/78

PENDING REVIEWED BY JR

MED-657-58 (R/3/77)

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

CIRCULATION AND RECORDS DEPARTMENT
STUDENT'S HISTORICAL RECORD DATE: 5-26-78

NAME: WELCH,PHILIP DAVID,
ADDRESS: 2107 E MERCER SEATTLE WA 98112
BIRTHDATE: 04/05/49
MEDICAL EDUCATION (SCHOOL YEAR):
UNIV OF WASHINGTON SCH OF MED SEATTLE WA 98105 1978
MEMBER OF AMA: YES

*** GENERAL INFORMATION REQUEST ***

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.

STATE OF WASHINGTON

Dixy Lee Ray
Governor

DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

April 24, 1978

Philip David Welch
2107 E. Mercer St.
Seattle, WA 98112

Dear Mr. Welch

This is to acknowledge receipt of your limited medical license application received in this office April 11, 1978.

The following is required to complete your application:

- ✓ Certified copy of medical school diploma (✓ a letter from the school with the seal and date of graduation will be accepted)
- Certification of postgraduate training
- Fee
- Certification of license in another state
- Chronology
- Letters of recommendation
- Affidavit
- Personal Data
- Verification of employment
- ✓ Other PHOTOGRAPH

Copies of all documents must be certified as true and unaltered copies of the originals.

Upon receipt of the requested documentation, your application will be acted upon.

Sincerely

JOAN BAIRD
ADMINISTRATOR

Joanne Redmond

By: (Mrs.) Joanne Redmond
Assistant Administrator
(206) 753-2205

JR:jm

MED-657-59 Ltd. Lic. Ack. Ltr.
(R/4/78)

STATE OF WASHINGTON

Dixy Lee Ray
Governor

DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

This is to certify that Philip David Welch, M.D. has been appointed as a resident* in Surgery Service at the Swedish Hospital Medical Center hospital for the period beginning June (Mo) 26 (Day) 1978 (Yr). The individual responsible for this resident's patient care activities will be James R. Caudrell, 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)

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have known PHILIP WELCH

for 1 years, from March 1977 to March 1978

during which period he was engaged in the study or active practice of medicine. To the best of my knowledge he is of good moral and professional character, is free from habits which might interfere with h/s professional activities and is worthy of holding a license to practice MEDICINE in the State of Washington.

Signature George F Odland M.D.

Address University Hospital R.M. 14

Licensed under laws of Washington

To practice Medicine (dermatology)

MED-657-12 Letter of Recommendation
(R/1/77)

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have known Philip Welch

for 1 years, from March 1977 to March 1978

during which period he was engaged in the study or active practice of medicine. To the best of my knowledge he is of good moral and professional character, is free from habits which might interfere with his professional activities and is worthy of holding a license to practice medicine in the State of Washington.

Signature Robert C. Figdor M.D.

Address 2231 E. Crescent Drive, Seattle WA 98112

Licensed under laws of the States of Washington and Michigan

To practice Medicine

MED-657-12 Letter of Recommendation
(R/1/77)

MEDICAL BOARD WORKSHEET

NAME Philip David Welch DATE OF RECEIPT 6/22/79

d.o.b. 4/5/49

1.	LICENSURE BY		
	a) National Board Waiver	✓	Board
	b) Reciprocity from _____		
	c) FLEX Waiver		
	d) LMCC		
	e) Examination		
2.	FEE	✓	
3.	ADDITIONAL PHOTOGRAPH		
4.	PROOF OF EDUCATIONAL EXPERIENCE		
	a) Medical School Diploma	✓	
	b) Postgraduate Medical Training	✓	
	c) Chronology	✓	incomplete
	d) Personal Qualifications	✓	
5.	FOREIGN GRADUATE		
	a) ECFMG		
	b) Medical School Subjects		
6.	LETTERS OF RECOMMENDATION	✓	
7.	AFFIDAVIT	✓	
8.	STATE CLEARANCE Mld. _____	✓	none
9.	AMA CLEARANCE Mld. 6-27-79	✓	

ADMINISTRATIVE RECOMMENDATION 4c

BOARD ACTION 3-19-80 indefinite

	LICENSE	EXAM
APPROVED	✓	
DISAPPROVED		

DATE 9-5-79

PENDING 4C

REVIEWED BY [signature]

MED-657-24 (R 8/75)

January 9, 1981

Philip D. Welch, M.D.
2107 E. Mercer
Seattle, WA 98112

Dr. Welch

We are pleased to advise that you have been issued Washington State Physician and Surgeon certification No. 0018862 dated 1/8/81. Enclosed you will find your wallet size license which bears your certificate number and certificate date. Your medical certificate will be forwarded to you as soon as it is engraved. This necessitates some delay and you will not receive the certificate for several months.

This office will send, as a courtesy, notification of your license renewal thirty (30) days prior to expiration date to the address on file. It is important that you keep our office advised, in writing, of any changes in your address so that you will receive your certificate and annual renewal notices.

Sincerely

JOAN BAIRD
ADMINISTRATOR

Joanne Redmond

Mrs. Joanne Redmond
Assistant Administrator
Health Care Services
(206) 753-2205

MED 657-10
(R/3/80)

DEPARTMENT OF LICENSING

TO: Philip D. Welch, M.D.

DATE: 9/11/80

FROM: Carol Berry
Medical Section

RE: Medical application

Please list, on the attached chronology, your activities from 6/78 to present.

If you have any questions, please do not hesitate to contact this office.
(206) 753-2205

DOL-200-6 Memo
(R/12/79)

DEPARTMENT OF LICENSING

TO: Philip D. Welch, M.D.

DATE: 9/11/80

FROM: Carol Berry
Medical Section

RE: Medical application

Please list, on the attached chronology, your activities from 6/78 to present.

If you have any questions, please do not hesitate to contact this office.
(206) 753-2205

DOL-200-6 Memo
(R/12/79)

PREVIOUS REGISTRATION

Welch, P.D.

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	
WASH	MED	78		TEMP			YES

PROFESSIONAL TRAINING AND EXPERIENCE*

List in chronological order all professional education and experience including college, university, medical school, osteopathic school, post-graduate training, internships, residencies and practice. Include **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	Name and Location of Institution, Place of Practice or Other	Degree or Certificate and Date Received, or Nature of Experience or Specialty
6/78	6/79	SWEDISH HOSP, SEATTLE, WA	INTERNSHIP
9/67	1/69	YALE UNIV	UNDERGRAD
1/69	9/71	INDEPENDENT EMPLOYMENT	
9/71	6/74	U of W - PRE-MED	BS - ZOOLOGY
9/74	6/78	UW SCH OF MEDICINE	MD

Welch, P.D.

STATE OF WASHINGTON

Dixy Lee Ray
Governor

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

RECEIVED
JUL 28 1980
DIVISION OF PROFESSIONAL LICENSING

June 27, 1979

Philip David Welch, M.D.
2107 E. Mercer
Seattle, WA 98112

Dear Dr. Welch:

Thank you for your medical application received in this office June 22, 1979.
The next meeting of the Board will be held on September 7-8, 1979
at which time your application will be reviewed, if complete. You will be advised of board decision approximately 2 weeks after the board meeting.

Application appears complete ( )

FLEX Certification
LMCC Certification
State Board Certification
National Board "Certification of Record"

Lacks the following (X) **

Postgraduate Training
Medical School Diploma
Medical School Subjects (MED-5)
Original E.C.F.M.G. Certificate
Other chronology

Copies of all documents must be certified as true.
Applications not complete prior to board meeting date indicated above, will be placed in our inactive file.

Remarks: **As of this date we have not received your National Board "Certification of Record" showing subjects and grades. Please complete your chronology by listing all professional education, using the enclosed xerox copy.

Sincerely,

By Nita Myers
Healing Arts Section

MED-657-14 App. Rec'd Ltr.
(R/9/75)

September 13, 1979

Philip David Welch, M.D.
2107 E. Mercer
Seattle, WA 98112

Dear Dr. Welch:

Your application and documents were presented to the Board of Medical Examiners on Sept. 7-8, 1979 for review.

No further action can be taken on your application until receipt of the following:

1. Complete chronology by listing all professional education, and updating from 6/79 to the present.

If you have any questions, please feel free to contact this office.

Sincerely,

JOAN BAIRD
ADMINISTRATOR

By (Mrs.) Joanne Redmond
Assistant Administrator
Medical/Nursing Services

JR/cmm

MED 657-011 (rev 1/78)

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

SURVEY DATA CENTER
DEPARTMENT OF PHYSICIAN STATISTICS

DATE: 07-20-79

NAME: WELCH,PHILIP DAVID, M.D.
ADDRESS: 2107 E MERCER SEATTLE WA 98112
BIRTHPLACE: HARTFORD,CT BIRTHDATE: 04/05/49
MEDICAL EDUCATION (SCHOOL YEAR):
UNIV OF WASHINGTON SCH MED,SEATTLE WA 98105 1978
NATIONAL BOARD CERTIFICATION: NOT REPORTED TO DATE
LICENSES:
NOT REPORTED TO DATE
PHYSICIAN'S PROFESSIONAL ACTIVITIES:
RESIDENT
PRIMARY SPECIALTY: OBSTETRICS AND GYNECOLOGY
SECONDARY SPECIALTY: UNSPECIFIED
TERTIARY SPECIALTY: UNSPECIFIED
SPECIALTY BOARD CERTIFICATION: NOT REPORTED TO DATE
MEMBER OF AMA: NOT MEMBER
NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NOT REPORTED TO DATE
PROFESSORIAL APPOINTMENT: NOT REPORTED TO DATE
CURRENT MEDICAL TRAINING: INTERN
HOSPITAL: SWEDISH HOSP MED CENTER SEATTLE WA 98104
DATES OF TRAINING: 7/78-06/79
SPECIALTY: GENERAL SURGERY
SPECIALTY: UNSPECIFIED
INTERNSHIP:
NOT REPORTED TO DATE
RESIDENCY:
NOT REPORTED TO DATE

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NATIONAL BOARD OF MEDICAL EXAMINERS • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

PHILIP D. WELCH, 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: WILLIAM B. HOLDEN
Chairman of the Board

SEAL

EDITHE J. LEVIT
President of the Board

Philadelphia, Pa.
07/02/79

Cert. # 201014

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of UNIV WASHINGTON SCH MED in JUNE 1978, whose birth date is 04/05/1949, 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
PART I passed 06/76		
Anatomy, incl. histology and embryology	495	80
Physiology	520	82
Biochemistry	555	84
Pathology	430	76
Microbiology, incl. immunology	595	87
Pharmacology and Materia Medica	475	79
Behavioral Sciences	610	88
(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**	530	82
Part II passed 04/78		
Internal medicine and the medical specialties	480	81
Surgery and the surgical specialties	510	83
Obstetrics and Gynecology	610	88
Public Health and Preventive Medicine	505	82
Pediatrics	605	87
Psychiatry	540	84
(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**	550	84
PART III passed 03/79		
A General Test of Clinical Competence		
(Minimum Passing Grade 290/75) AVERAGE	590	85.4
GENERAL AVERAGE (Parts I, II, and III)		83.8 (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.

Ann K. Heuerling
Secretary for Certification

06/22/79
Date

SEAL

Welch, P.D.

RECEIVED
AUG 3 1978
DIVISION OF
PROFESSIONAL LICENSING

The University of Washington

To all to whom these Letters shall come. Greeting:

The Regents of the University on recommendation of the Faculty of the School of Medicine and by virtue of the Authority vested in Them by Law have this day admitted

This is to certify this is a true copy.

Subscribed and sworn to before me
this 1st day of AUGUST 19 78

Vaughn A. Holden
Notary Public
King County-State of Wash.
Residing at Seattle

Philip David Welch

to the degree of

Doctor of Medicine

and have granted all the Rights Privileges and Honours thereto pertaining

Given at Seattle, in the State of Washington, this tenth day of June, in the year of our Lord one thousand nine hundred and seventy-eight and of the University the one hundred and eighteenth.

UNIVERSITY OF WASHINGTON · 1861 ·

Mary M. Gates
President of the Board of Regents

John R. Hogness
President of the University

Robert Wakefield
Dean of the School of Medicine

The Swedish Hospital Medical Center

747 Summit Avenue
Seattle, Washington 98104

Dept. of Medical Education
292-2265

June 7, 1979

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

Re: Philip D. Welch, M.D.

Dear Sir:

This is to verify that Dr. Philip D. Welch will have successfully completed his first year of post-graduate training at The Swedish Medical Center on June 24, 1979

Sincerely yours,

John L. Wright, M.D.
Director of Medical Education

JLW/kl

(Hospital Seal)

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have known Phil Welch MD

for 1 years, from July 1978 to Present

during which period he was engaged in the study or active practice of medicine. To the best of my knowledge he is of good moral and professional character, is free from habits which might interfere with his professional activities and is worthy of holding a license to practice Medicine in the State of Washington.

Signature Karl J Mayer MD

Address 1221 Madison #414 Seattle 98104

Licensed under laws of Washington

To practice Medicine

MED-657-12 Letter of Recommendation
(R/1/77)

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have known Philip Welch

for 10 years, from 1969 to 1979

during which period he was engaged in the study or active practice of medicine. To the best of my knowledge he is of good moral and professional character, is free from habits which might interfere with his professional activities and is worthy of holding a license to practice medicine in the State of Washington.

Signature Raymond J Clark MD.

Address 1145 Broadway

Licensed under laws of Wash -

To practice medicine

MED-657-12 Letter of Recommendation
(R/1/77)

June 27, 1979

Philip David Welch, M.D.
2107 E. Mercer
Seattle, WA 98112

Dear Dr. Welch:

Thank you for your medical application received in this office June 22, 1979.
The next meeting of the Board will be held on September 7-8, 1979
at which time your application will be reviewed, if complete. You will be advised of board decision approximately 2 weeks after the board meeting.

Application appears complete ( )

Lacks the following (X) **

FLEX Certification	Postgraduate Training
LMCC Certification	Medical School Diploma
State Board Certification	Medical School Subjects (MED-5)
National Board "Certification of Record"	Original E.C.F.M.G. Certificate
	Other chronology

Copies of all documents must be certified as true.
Applications not complete prior to board meeting date indicated above, will be placed in our inactive file.

Remarks: **As of this date we have not received your National Board "Certification of Record" showing subjects and grades. Please complete your chronology by listing all professional education, using the enclosed xerox copy.

Sincerely,

By _____
Healing Arts Section

MED-657-14 App. Rec'd Ltr.
(R/9/75)

Application File_436819_pdf-r.pdf redacted on: 1/2/2015 10:03

Redaction Summary (1 redaction)

1 Privilege / Exemption reason used:

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

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