Credential View Screen [update]

TERESA F. GIPSON

Address:

◉ Public ○ Mail ○ Renewal Mail

[change public address]
TERESA F. GIPSON
PO Box 746
Beaverton, OR 97075-0746

ID	866816
Warnings	
SSN/FEIN	2 - DOH Licens...
Contact Standing	Living
Contact Type	INDIVIDUAL
Birth Date	05/08/1959
Public File	**YES**
Mailing List	
Email:	**gipsont@ohsu.edu**

Contact
Audit
Public Cases
Cont. Edu
Documents
Owned By/Key Mgmt
Exams
Experience
Notes
Schools
Supervises
SupervisedBy
Librarian
Application
Other State License

Comments:

Physician And Surgeon License [update] [form letter]

Credential #	**MD.MD.60028041**
Application Date	06/20/2008
Effective Date	
Expiration Date	
First Issuance Date	
Last Date Of Contact	06/20/2008
CE Due Date	

Credential Status	**PENDING** (06/20/2008)
Status Reason	INITIAL APPLICATION IN PROCESS
Amount Due	**$0.00**
Date Last Activity	7/1/2008 9:05:52 AM
Last Updated by	Goldschmidt, Lisa B
Certificate Sent Date	
Work Queue	Legacy, DOH

Audit
Documents
Workflow
Key Mgmt
Fees
Notes
Print Docs
Comp. Audit
Renewal

Comments:

Supervises | **User Defined License Data** | **Workflow** | **Legacy** | **HIPDB**

[update]

Medical Quality Assurance Commission
Physician Application Worksheet

Name GIPSON TERESA Date of Birth 05/08/1959

Date Received 6/30/08 Cash Number _____ Candidate Number _____

x	WSP Check	x	Fee	x	Photo	x	Data1-13	x	AIDS	x	Attest	x	SSN		EBAHR

Chronology Complete

☐ Temp Permit Issued Number: _____

7/1/08	7/1/08		
FSMB	AMA	ECFMG	ARCHIVE FILE

Documentation Received	Malpractice Cases	Synopsis	Disposition
	1		
	2		
	3		
	4		

Medical School School Code _____ ☐ U.S. ☐ Canadian ☐ International

Name GEORGETOWN Year of Degree 1994 ☒ Transcripts ☐ Translations

Examination Type ☐ National Boards ☐ FLEX ☒ USMLE ☐ State Exam ☐ LMCC 6/9/08 Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Gradu: Training Programs	Accrediation Verified
6/29/08	OHSU 7/94-6/97				
7/1/08	U OF ROCHESTER 8/04-3/07				

6/11/08	OR	6/6/08	SILVERTON
6/16/08	NY	6/4/08	OHSU

Signature _____ Date 7/18/08

Comments:

Deficiency Letters:

☐	January	☐	April	☐	July	☐	October	☐	
☐	February	☐	May	☐	August	☐	November	☐	
☐	March	☐	June	☐	September	☐	December	☐	

385-

PHYSICIAN & SURGEON

Washington State Department of Health

REVENUE SECTION

PRINT NAME Gipson, T

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236

94

DOBS

0035-6/17/2008 10:28:28 AM-001 $335.00

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 1099
Olympia, WA 98507-1099
360.236.4700

Background Check Processed
JUN 8 0 2008
WSP/NFDB/HPDB:

RECEIVED
Department of Health
Investigation Service Unit
JUN 20 2008

HPQA
RECEIVED
JUN 18 2008

Revenue 0252090000

CSC

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS

Medical Practice License Application for MDs only

☐ National Boards ☐ Other State Exam ☐ LMCC (Must have been obtained after 1969)
☐ Flex Examination ☒ USMLE Examination

Please type or print clearly. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. Make sure you have read and understand the instructions.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

2 - DOH Licensee Social Security Number - RCW 42.56.350(1)

Name ☐ Male ☒ Female | First: TERESA | Middle: FRANCES | Last: GIPSON

Birth date (mm/dd/yyyy): 05/08/1959

Place of birth: City: LOS ANGELES | State: CA | Country: LOS ANGELES

Address: P.O. BOX 746

City: BEAVERTON | State: OR | Zip: 97075 | County: WASHINGTON

Country: USA

Phone: 1 - DOH Licensee Health Professional ... | Fax: (503) 494 2746 | Cell: 1 - DOH Licensee Health Professional Home A...

email address: gipsont@ohsu.edu

Mailing address if different from above of record

City | State | Zip | County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

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

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☒ No

If yes, list name(s):

Medical Specialty

Medical school: GEORGETOWN UNIVERSITY Year of graduation: 1994

Medical specialty: FAMILY MEDICINE

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach an explanation. ..... ☐ ☒

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

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

> **Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

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

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ..... ☐ ☒

4. Are you currently engaged in the illegal use of controlled substances? ..... ☐ ☒

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

> **Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile, in Washington or another jurisdiction state? ..... ☐ ☒

> **Note: If you answered yes, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and your application will not be considered.**
>
> **To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

2. Personal Data Questions (Cont.)

	Yes	No
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☒
b. Diverted controlled substances or legend drugs?	☐	☒
c. Violated any drug law?	☐	☒
d. Prescribed controlled substances for yourself?	☐	☒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☒
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☒
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☒
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☒
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☒
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☒
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☒

3. Medical Education and Experience

Provide a chronological listing of your educational preparation and post-graduate training. If you need additional space, attach a separate piece of paper.

Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Diploma or degree obtained (Quote titles in original language and translate to English.)	Number of years attended	Dates granted	
			Start	End
Medical education (list all medical schools attended)				
GEORGETOWN UNIVERSITY	M.D.	4	8/90	6/94
Post graduate training (list all programs attended)				
OREGON HEALTH & SCIENCES UNIV	RESIDENCY	3	7/94	6/97
U. OF ROCHESTER	FELLOWSHIP	2 1/2	8/04	3/2007

4. Professional Experience

In chronological order list all professional experience received since graduation from medical school to the present. (Exclude activities listed under other sections, identify any periods of time break of 30 days or more.) If you need additional space, attach a separate piece of paper.

Name and location of institution	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Nature of experience or specialty
LOCUMS / VACATION AFTER RESIDENCY	7/1/97	9/5/97	
SALUD MEDICAL CENTER	9/6/97	12/30/03	STAFF PHYSICIAN
SILVERTON HOSP, KENYA	12/31/03	8/20/04	RESEARCH
Oregon Health & Sciences Univ	3/07	present	Faculty Physician

5. Hospital Privileges (Excluding post-graduate training hospital privileges.)

Excluding post-graduate training, list hospitals where all privileges that have been granted within the past five years. If you need additional space, attach a separate piece of paper.

Name of hospital	Dates attended	
	Start date	End date
SILVERTON HOSPITAL, SILVERTON OR	9/97	2004
OREGON HEALTH SCIENCES, PORTLAND OR	3/07	present

6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. List in chronological order, starting with the most current.

State	Date license issued	License Number	Basis of License		Status of license	Any limitations on license
			Exam date passed	Endorsement		
OREGON	7.19.96	MD19918	6/95	USMLE STEP 3	ACTIVE	☒ No ☐ Yes
NEW YORK	5.25.04	232516	"	"	INACTIVE	☒ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four (4) of education in the prevention, transmission, and treatment of AIDS. This education included topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

Applicant's initials	Date
TFG	6.10.08

8. Applicant's Attestation

I, TERESA FRANCES GIPSON, declare under penalty of perjury under the
(Print applicant name clearly)
laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated 10 June 2008 at Beaverton, Oregon (city, state)

By: Teresa F Gipson
Signature of applicant

9. Applicant's Photograph

Photo Here

Height 6'3"
Weight 254
Hair color Black
Color of eyes Brown

Teresa F Gipson
6.10, 2008

Name Teresa F. Gipson
Student ID 2 - DOH Licens...
Admitted Form SAGINAW VALLEY STATE COLLEGE MI
MI

GEORGETOWN UNIVERSITY
The Office of the Registrar
The School of Medicine
Washington, DC 20057-1421

Course	Title	Grade
	Degrees Awarded: May 28, 1994	
	Doctor of Medicine	
	Georgetown University DC	
	Major: Medicine	
	Entering Program:	
	School of Medicine	
	Non-degree Program	
	Undeclared	
	----------Academic Year 1989-90----------	
	Class of Special	
ANTM-407	EMBRYOLOGY	P
BCHM-403	BIOCHEMISTRY	P
PBIM-402	PHYSIOLOGY	HP
SPPM-180	SELECTED TOPICS:BIOCHEMISTRY	S
SPPM-181	SELECTED TOPICS: PHYSIOLOGY	S
SPPM-186	SPEC.TOPICS IN DECISION MAKING	S
	ADMITTED TO FIRST YEAR CLASS 8-15-90	
	Program Changed To:	
	Doctor of Medicine	
	Medicine	
	----------Academic Year 1990-91----------	
	Class of 1994	
ANTM-405	GROSS ANATOMY	P
ANTM-406	MICROSCOPIC ANATOMY	P
ANTM-408	NEUROBIOLOGY	P
CMEM-404	INTRODUCTION TO THE PATIENT I	H
CMEM-406	AMBULATORY CARE	H
CMEM-407	BIOSTATISTIC & EPIDEMIOLOGY	H
MEDM-403	COMMUNITY & FAMILY MEDICINE I	HP
MEDM-404	COMMUNITY & FAMILY MEDICINE II	H
MEDM-405	PHYSICAL DIAGNOSIS-NON GRADED	
	----------Academic Year 1991-92----------	
	Class of 1994	
CMEM-422	AMBULATORY CARE II	H
CMEM-423	MEDICAL DATA AND REASONING	H
MEDM-423	IMMUNOLOGY	P
MEDM-424	PHYSICAL DIAGNOSIS	HP
MEDM-428	PROBLEM SOLVING II	P
MEDM-429	SPECIAL DIAGNOSIS-NONGRADED	
MICM-422	MICROBIOLOGY	HP
PATM-422	PATHOLOGY	P
PHRM-422	PHARMACOLOGY	P
PTYM-170	AN INTROD. TO MIND-BODY MED.	S
----------	--No Further Entries This Column--	

Course	Title	Grade
	----------Academic Year 1992-93----------	
	Class of 1994	
MEDM-440	MEDICINE	HP
NEUR-440	NEUROLOGY	HP
OBGY-441	OB-GYN	H
PEDI-441	PEDIATRICS	H
PTYM-440	PSYCHIATRY	H
RADM-440	RADIOLOGY	HP
SURG-440	SURGERY	HP
	----------Academic Year 1993-94----------	
	Class of 1994	
4255-440	FAMILY PRACTICE	H
4255-933	COMMUNITY & FAMILY MED. - GTOWN	P
4255-999	FAMILY PRACTICE - KENYA	P
4280-510	PEDIATRICS -- NASSAU, BAHAMAS	HP
4295-440	PSYCHIATRY - GTN	HP
4295-501	CHILD & ADOLESCENT PSYCHIATRY	H
4310-445	EMERGENCY MEDICINE - FAIRFAX	H
4320-445	MEDICINE - ARLINGTON	HP
4353-445	SENIOR SURGICAL CLERKSHIP	HP
	Requirements completed for Doctor of Medicine	
	----------End of Medical Academic Record----------	

MEDICAL SCHOOL EXPLANATION OF GRADING SYSTEM

H – HONORS
HP – HIGH
P – PASS
F – FAILURE
W – WITHDREW
I – INCOMPLETE
S – SATISFACTORY
U – UNSATISFACTORY

DENTAL SCHOOL EXPLANATION OF GRADING SYSTEM

PRIOR TO CLASS OF 1982

A GRADE OF 75 OR HIGHER SIGNIFIES SATISACTORY PERFORMANCE.

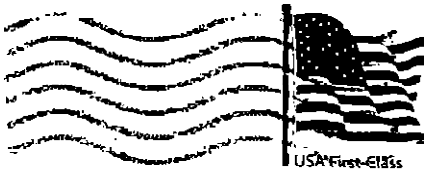
A GRADE OF 74 OR BELOW SIGNIFIES UNSATISACTORY PERFORMANCE.
W – WITHDREW
I – INCOMPLETE

EFFECTIVE WITH THE CLASS OF 1982

A – 4.00 EXCELLENT
B – 3.00 SUPERIOR
C – 2.00 ADEQUATE
D – 1.00 MINIMUM PASSING
F – 0.00 FAILURE
I – INCOMPLETE
W – WITHDREW
S – SATISFACTORY
U – UNSATISFACTORY
( ) – ADVISORY GRADE

GEORGETOWN UNIVERSITY MEDICAL CENTER
Office of Academic Records
3900 Reservoir Road NW
Med-Dent Annex Room 5
Box 571418
Washington DC 20057

WASHINGTON DC 200
09 JUL 2005 PM 6T T



DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION 10:31 PM
P.O. BOX 47866
OLYMPIA, WA 98504-7866

OFFICIAL TRANSCRIPT

98504+7866

Jeanne Walther

1

NOT OFFICIAL IF SEAL IS BROKEN

US·MLE
United States
Medical
Licensing
Examination™

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

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

Date : 06/09/2008

Recipient:

Washington Medical Quality Assurance Commission
ATTN: Blake Maresh, Exec Director
310 Israel Road SE
Tumwater, WA 98501

Examinee: Gipson, Teresa
Alt Name(s): Gipson, Teresa Frances

Examinee ID#: 4-011-667-5
Date of Birth: 05/08/1959

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

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	09/21/1993	Pass	188	176	78	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	03/30/1994	Pass	184	167	78	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
OREGON	06/27/1995	Pass	187	176	78	75	

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

Interpretation of results

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

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

STEP 2 CLINICAL SKILLS (CS)

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

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

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

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

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

ANNOTATIONS APPEARING AS "NOTE"

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

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

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

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360.236.4700

RECEIVED
JUN 7 2008
DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

MD

To: Post Graduate Training Program Director

Facility name Oregon Health & Sciences University
Address 3181 SW Sam Jackson Park Rd
Portland OR

RE: Verification/evaluation of training

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

Applicant (Print or type) TERESA F. GIPSON Birth date 5.8.59

Signature of applicant Teresa F Gipson

1. Teresa F. Gipson is or was engaged in postgraduate training in our program
from July 1994 to June 1997 to
(Beginning date (month & year)) (Ending date (month & year))
in the field of Family Medicine

2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? ☒ Yes ☐ No
If no, does this program qualify the applicant to become board certified? ☐ Yes ☐ No

3. Was the participant placed ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☒ No

If yes, please explain _____

Return to:
Medical Quality Assurance Commission
P O Box 47866, Olympia, WA 98504-7866
360.236.4700

OREGON HEALTH & SCIENCE UNIVERSITY

Signature Roger D Garvin
Title Roger D Garvin
Please type or print
Hospital _____
Address 3181 SW Sam Jackson Park Rd
Mail code: FM Portland, OR 97239
Date 6/13/08
Telephone 503 494 3367

DOH 657-034 (REV05/2008)

Health

Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360.236.4700

MD

RECEIVED

JUN 1 2008

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

To: Post Graduate Training Program Director

Facility name U of Rochester, Department of Family Medicine

Address 777 S. Clinton Ave

Rochester NY 14620

RE: Verification/evaluation of training

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

Applicant (Print or type) TERESA F. GIPSON Birth date 5.8.59

Signature of applicant Teresa F Gipson MD

1. TERESA F. GIPSON is or was engaged in postgraduate training in our program
   from 08/01/04 (Beginning date (month & year)) to 02/28/07 (Ending date (month & year)) to
   in the field of REPRODUCTIVE HEALTH - FAMILY MEDICINE FELLOWSHIP
2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? ☐ Yes ☒ No
   If no, does this program qualify the applicant to become board certified? ☐ Yes ☒ No
3. Was the participant placed ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☒ No

If yes, please explain _____

Return to:
Medical Quality Assurance Commission
P O Box 47866, Olympia, WA 98504-7866
360.236.4700

Signature Susan M. Gardner

Title FELLOWSHIP COORDINATOR

Please type or print

Hospital Highland (Hospital) Family Medicine
Family Medicine Research & Fellowship Pgms

Address 1381 South Avenue

Rochester, NY 14620

Date 6/19/08

Telephone (585) 506-9484 x128

DOH 657-034 (REV05/2008)

Oregon Medical Board

Verification of Licensure

SUBJECT TO TERMS AND CONDITIONS
Information current as of: 06/09/2008
Query Time: 2008-06-10 14:37:06.936093
Session Info: 172.21.5.5/406CE553F957F060CE2AC9C57228E2CC

This site is a primary source for verification of license credentials consistent with JCAHO and NCQA standards.

Licensee:	**GIPSON, TERESA FRANCES MD**
Gender:	Female
Year of Birth:	1959

LOCATION

City:	Portland	**Business Phone:**	503-494-8311
County:	MULTNOMAH		
State:	OREGON		

LICENSE

Number:	**MD19918**		
Type:	Medical Physician and/or Surgeon		
Basis:	United States Medical Licensing Exam		
Issued:	07/19/1996	Current Status:	Active
Expires:	12/31/2009		

OTHER LICENSES

Number	Effective Date	Expiration Date	License Type
LL06204	07/01/1995	06/25/1996	LLPG
LL06834	06/26/1996	07/19/1996	LLS

EDUCATION

School:	Georgetown Univ Sch/Med		
Graduation:	05/28/1994	**Reported Specialty:**	Family Medicine
Location :	Washington, DC		

BOARD ORDERS

Standing: Unrestricted - No public orders on file

Oregon Medical Board
1500 SW 1st Ave, Suite 620
Portland, OR 97201

(971) 673-2700

(Board Seal)
Verification prepared by: R. Washington

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

RECEIVED
JUN 16 2008
DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, GIPSON TERESA FRANCES
WAS ISSUED LICENSE/CERTIFICATE NUMBER 232516 FOR THE PRACTICE OF MEDICINE ON 05/25/04.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: 05/08/59
SCHOOL ATTENDED: GEORGETOWN UNIVERSITY
DATE OF GRADUATION: 05/28/94
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
06/95								00078	OOSOR
03/94						00078			
09/93			00078						

EXMS TAKEN=03

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: NO REG PERIOD ENDS:
ADDRESS: FAM MED DEPT- OHSU 3181 SW SAM JACKSON P ARK RD PORTLAND OR 97239-0000
DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I MARTIN CARMODY, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

OP026 041

Martin Carmody 06/10/08
PRINCIPAL CLERK

OREGON HEALTH & SCIENCE UNIVERSITY

Medical Staff Office

Mail code: MBS, 3181 SW Sam Jackson Park Rd., Portland, OR 97239
503-494-8014 phone, 503-494-2251 fax

June 16, 2008

VIA FACSIMILE (360) 236-4768
Medical Quality Assurance Commission
1300 SE Quince Street
PO Box 47866
Olympia, WA 98504-7866

In response to your recent inquiry regarding practitioner: Teresa F. Gipson, MD.

Our Medical Staff Office records show that the provider listed above is a medical staff member of our hospital with clinical privileges in good standing as follows:

Department/Division: Family Medicine

Staff Status: Active

Effective Dates: 03/19/2007 to Current

Prior appointment date if any:

If you have any questions, please call the Medical Staff Office at 503 494-8014.

Lisa D. Guy
Medical Staff Office

FAMILY MEDICINE

Levels of Approval
Medical Board: Yes 03/19/2007

	Requested	Granted	Monitored
CORE PRIVILEGES WITH ADULTS			
Admission, work-up, diagnosis and treatment including consultation when appropriate – of general medical and surgical problems, including performance of procedures as listed on the core procedure list. Privileges will be consistent with the scope of care as indicated in the Program Requirements for Residency Education in Family Practice.	Y	Y	N
CORE PRIVILEGES WITH CHILDREN			
Admission, work-up, diagnosis and treatment – including Consultation when appropriate – of general medical and surgical problems of patients from birth to 18 years of age, including performance of procedures as listed on the core procedure list. Privileges will be consistent with the scope of care as indicated in the Program Requirements for Residency Education in Family Practice.	Y	Y	N
CORE PRIVILEGES IN MATERNITY CARE			
Care for pregnant women, including prenatal care, delivery, and postpartum care, and including consultation when appropriate. Privileges will be consistent with the scope of care as prescribed in the Program Requirements for Residency Education in Family Practice.	Y	Y	N
CORE PRIVILEGES WITH ADULTS include the following:			
Allergy Desensitization			
Allergy Skin Testing			
Advanced Cardiac Life Support	Y	Y	N
Anaphylaxis, Emergency Management of	Y	Y	N
Arterial Cannulation			
Arterial Puncture for Blood Gas Sampling	Y	Y	N
Arthrocentesis	Y	Y	N
Aspiration of Bursa	Y	Y	N
Assistant at Major Surgery	Y	Y	N
Bone Marrow Aspiration and Biopsy			
Breast Cyst Aspiration	Y	Y	N
Breast Mass Biopsy	Y	Y	N
Cardiopulmonary Resuscitation, Emergency	Y	Y	N
Cardioversion, Emergency	Y	Y	N
Casting/Orthopedic Immobilization	Y	Y	N
Catheterization of the Urinary Bladder	Y	Y	N
Central Venous Line Placement and Venous Pressure Monitoring			
Cervical Polypectomy			
Chest Intubation, Emergency	Y	Y	N
Colposcopy/Biopsy	Y	Y	N
Cricothyrotomy, Emergency			
Cryotherapy/Cryosurgery	Y	Y	N
Defibrillation, Electrical, Emergency	Y	Y	N
Dilation and Curettage	Y	Y	N
Dislocation, Closed Reduction			
Electrodesiccation and Curettage			
Endometrial Aspiration, Biopsy	Y	Y	N
Endotracheal Intubation			

Foreign Body Removal, Ear	Y	Y	N
Foreign Body Removal, Eye	Y	Y	N
Gastric Aspiration, Lavage	Y	Y	N
Hemorrhoidal Banding			
Hordeolum Drainage	Y	Y	N
Incision and Drainage of Abscess	Y	Y	N
Intralesional Injection of Corticosteroids	Y	Y	N
Intravenous Catheter Placement	Y	Y	N
Intravenous Medications	Y	Y	N
Laceration, Suturing	Y	Y	N
Laryngoscopy, Indirect and Direct			
Lumbar Puncture	Y	Y	N
Lymph Node Biopsy			
Myringotomy			
Nasal Packing	Y	Y	N
Nasogastric Tube, Tube Feeding	Y	Y	N
Norplant Insertion and Removal	Y	Y	N
Paracentesis, Abdominal	Y	Y	N
Paronychia, Incision and Drainage			
Placement and Removal of Intrauterine Contraceptive Device	Y	Y	N
Polypectomy, Rectal			
Preoperative Evaluation of Surgical Patients	Y	Y	N
Proctosigmoidoscopy			
Regional Nerve Block Anesthesia			
Sclerotherapy of Varicose Veins			
Skin Lesions, Application of Caustics to Lesions, Benign	Y	Y	N
Skin or Subcutaneous Tissue, Local Excision	Y	Y	N
Subungual Hematoma, Evacuation	Y	Y	N
Therapeutic Abortion by Suction Curettage	Y	Y	N
Thoracentesis	Y	Y	N
Thrombosed Hemorrhoid, Evacuation of	Y	Y	N
Toenail Removal	Y	Y	N
Tonometry, Ocular	Y	Y	N
Transfusion	Y	Y	N
Transtracheal Aspiration	Y	Y	N
Vasectomy	Y	Y	N
Venous Cutdown			
CORE PRIVILEGES WITH CHILDREN include the following:			
Allergy Desensitization			
Advanced Cardiac Life Support	Y	Y	N
Anaphylaxis, Emergency Management of	Y	Y	N
Arterial Puncture for Blood Gas Sampling	Y	Y	N
Arthrocentesis	Y	Y	N
Aspiration of Bursa	Y	Y	N
Assistant at Major Surgery	Y	Y	N
Bone Marrow Aspiration and Biopsy			
Cardiopulmonary Resuscitation, Emergency	Y	Y	N
Cardioversion, Emergency	Y	Y	N
Catheterization of the Urinary Bladder	Y	Y	N
Chest Intubation, Emergency	Y	Y	N
Circumcision, Infant	Y	Y	N
Cricothyrotomy, Emergency			
Cryotherapy/Cryosurgery	Y	Y	N
Defibrillation, Electrical, Emergency	Y	Y	N
Dislocation, Closed Reduction	Y	Y	N
Electrodesiccation and Curettage	Y	Y	N

Endotracheal Intubation	Y	Y	N
Foreign Body Removal, Ear	Y	Y	N
Fracture, Closed Reduction	Y	Y	N
Gastric Aspiration, Lavage	Y	Y	N
Hordeolum Drainage	Y	Y	N
Incision and Drainage of Abscess	Y	Y	N
Intralesional Injection of Corticosteroids	Y	Y	N
Intravenous Catheter Placement	Y	Y	N
Laceration, Suturing	Y	Y	N
Lumbar Puncture	Y	Y	N
Lymph Node Biopsy	Y	Y	N
Myringotomy	Y	Y	N
Nasal Packing	Y	Y	N
Nasogastric Tube, Tube Feeding	Y	Y	N
Paracentesis, Abdominal	Y	Y	N
Paronychia, Incision and Drainage	Y	Y	N
Preopertive Evaluation of Surgical Patients	Y	Y	N
Regional Nerve Block	Y	Y	N
Resuscitation, Newborn	Y	Y	N
Skin Lesions, Application of Caustics to Lesions, Benign	Y	Y	N
Skin or Subcutaneous Tissue, Local Excision	Y	Y	N
Sprains and Strains, Management of	Y	Y	N
Subungual Hematoma, Evacuation	Y	Y	N
Suprapubic Tap of Urinary Bladder	Y	Y	N
Thoracentesis	Y	Y	N
Toenail Removal	Y	Y	N
Tonometry, Ocular	Y	Y	N
Transfusion	Y	Y	N
Transtrachael Aspiration			
Venous Cutdown			
CORE PRIVILEGES IN MATERNITY CARE include the following:			
Assistant at Major Surgery	Y	Y	N
Biophysical profile/ultrasound	Y	Y	N
Cardiopulmonary Resuscitation, Emergency	Y	Y	N
Catheterization of the Urinary Bladder	Y	Y	N
Colposcopy/Biopsy	Y	Y	N
Contraction and non-contraction fetal stress tests	Y	Y	N
Culdocentesis	Y	Y	N
Dilation and Curettage	Y	Y	N
Endometrial Aspiration, Biopsy	Y	Y	N
Episiotomy	Y	Y	N
Fetal Monitoring, Electronic	Y	Y	N
Incision and Drainage of Abscess	Y	Y	N
Intravenous Catheter Placement	Y	Y	N
Intravenous Medications	Y	Y	N
Labor Induction	Y	Y	N
Laceration, Suturing	Y	Y	N
Manual Removal of the Placenta	Y	Y	N
Norplant Insertion and Removal	Y	Y	N
Placement and Removal of Intrauterine Contraceptive Device	Y	Y	N
Preoperative Evaluation of Surgical Patients	Y	Y	N
Proctosigmoidoscopy			
Pudendal Block Anesthesia	Y	Y	N
Regional Nerve Block Anesthesia	Y	Y	N
Resuscitation, Newborn	Y	Y	N
Skin Lesions, Application of Caustics to Lesions, Benign	Y	Y	N

Therapeutic Abortion by Suction Curettage	Y	Y	N
Ultrasound, Obstetrical - Basic	Y	Y	N
Vacuum Extraction Delivery	Y	Y	N
Transfusion	Y	Y	N
Vaginal Lacerations, Repair of	Y	Y	N
Vertex Delivery	Y	Y	N
SUPPLEMENTAL SPECIAL PRIVILEGES			
Moderate sedation	Y	Y	N
Deep sedation			
Fluoroscopy (one completed exam is required).			
Cesarean section			
Colonoscopy			
Esophagogastroduodenoscopy			
Exercise stress testing			
Forceps delivery			
Laparoscopic tubal ligation			
Obstetrics ultrasound - intermediate	Y	Y	N
ADDITIONAL PRIVILEGE ITEMS AND/OR CONDITIONS			

Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360.236.4700

RECEIVED
DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

MD

TO: Hospital Administration (Excluding post graduate training)

Name of licensing agency SILVERTON HOSPITAL, MEDICAL STAFF OFFICE

Address 342 Fairview

SILVERTON, OREGON

RE: Verification and evaluation of privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

Applicant (print or type) TERESA F. GIPSON Birth date 5/8/1959

Signature of applicant Teresa F Gipson MD

1. Teresa Gipson MD now has/has had admitting or speciality privileges at this hospital

from 09/23/1997 (Beginning date (month & year)) to 04/2007 (Ending date (month & year))

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

☐ Yes ☒ No If yes, please explain _____

3. Has the applicant ever been asked to resign? ☐ Yes ☒ No If yes, please explain _____

Return to:

Medical Quality Assurance Commission
P O Box 47866 Olympia, WA 98504-7866
360.236.4700

Signature Jan Buller

Title Jan Buller Mgr. Med Staff Office
(Please type or print)

Hospital Silverton Hospital

Address 342 Fairview

Silverton OR 97381

Date 6/13/08

Telephone 503-873-1562

DOH 657-017 (REV05/2008)

Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360.236.4700

MD

TO: Hospital Administration (Excluding post graduate training)

RECEIVED
JUN 4 (1 2008
DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

Name of licensing agency Oregon Health & Sciences University

Address 3181 SW Sam Jackson Park Rd.
Portland, OR

RE: Verification and evaluation of privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

Applicant (print or type) TERESA F GIBSON Birth date 5·8·59

Signature of applicant Teresa Gipson

1. Teresa Gipson, MD now has/has had admitting or speciality privileges at this hospital
from 3-19-2007 to Current
Beginning date (month & year) Ending date (month & year)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

☐ Yes ☒ No If yes, please explain _____

3. Has the applicant ever been asked to resign? ☐ Yes ☒ No If yes, please explain _____

Return to:

Medical Quality Assurance Commission
P O Box 47866 Olympia, WA 98504-7866
360.236.4700

N/A

Signature _____
Title Supervisor, Med Aff
Please type or print
Hospital OHSU
Address 3181 SW Sam Jackson PK Rd
Portland, OR 97239
Date 6·17·08
Telephone 503-494-8014

DOH 657-017 (REV05/2008)

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

TERESA FRANCES GIPSON MD
3181 SW SAM JACKSON PRK RD
PORTLAND OR 97239-3011

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: UNKNOWN

Birthdate: 05/08/1959
Birthplace: LOS ANGELES, CA UNITED STATES OF AMERICA

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: FAMILY MEDICINE
Secondary Specialty: UNSPECIFIED

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

AMA membership: NON MEMBER

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

Current and/or Historical Medical School:

GEORGETOWN UNIV SCH OF MED, WASHINGTON DC 20007
Degree Awarded: Yes
Degree Year: 1994

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

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

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

Institution: OR HLTH SCI UNIV HOSP — **State:** OREGON
Specialty : FAMILY MEDICINE — 07/1994 - 06/1997 (VERIFIED)

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

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
NEW YORK	MD	05/25/2004	NOT RPTD	INACTIVE	UNLIMITED	01/11/2008
OREGON	MD	07/19/1996	12/31/2009	ACTIVE	UNLIMITED	05/19/2008

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

ECFMG Certfication:

Applicant Number:

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

Federal Drug Enforcement Administration:

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

DEA Number *	Schedule	Expiration Date	Last Reported
XXXXXX083	22N 33N 4 5	09/30/2010	06/04/2008

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

AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

Specialty Board Certification(s)*:

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

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

Certifying Board: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY MEDICINE
Certificate Type: GENERAL

Duration	Effective	Expiration	Occurrence	Last Reported
TIME LIMITED	07/11/2003	12/31/2010	RE-CERT	06/12/2008
TIME LIMITED	07/11/1997	12/31/2004	INITIAL(**)	06/12/2008

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

Medicare/Medicaid Sanction(s):

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

Other Federal Sanction(s):

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

AMA Physician Profile

Additional Information:

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

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

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

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

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

		WASHINGTON			
5	Buxbaum, Evan	12/31/1968	034020	2001	19583554
		LICENSE HISTORY State Board ALASKA VERMONT			
8	Chu, Jerry	03/03/1976	033100	2002	19583562
		LICENSE HISTORY State Board NEW YORK			
10	Gade, george	04/13/1947	005030	1983	19583564
		LICENSE HISTORY State Board CALIFORNIA FLORIDA			
9	Gipson, Teresa	05/08/1959	009020	1994	19583563
		LICENSE HISTORY State Board NEW YORK OREGON			
13	Kelley, Kal	03/29/1979	044080	2006	19583568
		LICENSE HISTORY State Board WASHINGTON			
11	Knight, George	11/28/1975	048010	2004	19583566
		LICENSE HISTORY State Board IOWA NEBRASKA			

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

Washington State Department of Health

Medical Quality Assurance Commission
P.O. Box 1099
Olympia, WA 98507-1099
360.236.4700

RECEIVED
JUN 19 2008
DEPARTMENT OF HEALTH
HPQA Section 6

Temporary Permit Request

I hereby request a **one time only temporary permit**. I understand that the temporary permit shall expire upon the issuance of a license, initiation of an investigation by the commission, or 90 days, whichever occurs first.

Teresa F. Gipson MD — Signature
6.10.2008 — Date

TERESA FRANCES GIPSON — Print or type full name
5.8.59 — Date of birth

P.O. Box 746 — Mailing address

BEAVERTON — City
OR — State
97075 — Zip Code

Please note: "WAC 246-12-340 Refund of Fees. Fees submitted with application for initial credentialing, examinations, renewal, and other fees associated with the licensing and regulation of the profession are non-refundable."

General Information

Must be licensed in a recognized jurisdiction. See list on page two.

A temporary permit may be issued upon receipt of the following:

1. Completed application form.
   a) Personal data questions 1-10 must ALL be negative, excluding #10 regarding malpractice.
2. Temporary permit request form.
3. Application and temporary permit fees paid.
4. A clear Federation of State Medical Boards (FSMB) data bank clearance report.
5. A clear American Medical Association Profile.
6. Written verification from ALL states in which the applicant was or is licensed.

For Office use only

☐ Approved
☐ Disapproved
Review date _____

_____
Signature

STATE OF WASHINGTON
WASHINGTON STATE DEPARTMENT OF HEALTH

MEDICAL QUALITY ASSURANCE COMMISSION

P.O. Box 47866, Olympia, Washington 98504-7866

July 14, 2008

Teresa Gipson MD
POB 746
Beaverton OR 97075

Dear Dr Gipson

This is to acknowledge receipt of your application for physician and Surgeon licensure in the state of Washington.

Your application and fee of $385.00 was received on June 30, 2008

MISSING ITEMS
Medical School Transcripts

A deficiency letter, if that is what you have chosen, will be sent about every four to six weeks until the application is considered complete. Please understand deficiency letters are our way of notifying you what is lacking in your file. **If you choose to use email as your way of checking on your application, that may be done at any time.**

Please note: while this information was contained in the application packet you had been sent and is stipulated in Washington Administrative Code (WAC) 246-12-020(3), let me reiterate that upon approval, your initial license will be issued *only* to your next birthday after the approval date – unless your birthday falls within 90 days of approval, in which case it will expire on your second birthday following approval.

If you have any further questions or need additional information, email me at **betty.elliott@doh.wa.gov**, or write to me at Department of Health, Medical Quality Assurance Commission, P O Box 47866, Olympia, WA 98504-7866.

Sincerely,
Betty Elliott
Betty Elliott
Customer Service Specialist 2

Application File_511616_pdf-r.pdf redacted on: 5/14/2015 13:38

Redaction Summary (5 redactions)

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2 Privilege / Exemption reasons used:

1 -- "DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2)" (2 instances)

2 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (3 instances)

Page 1, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 5, DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2), 2 instances
Page 5, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 10, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance