



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

Department of Commerce, Community,
and Economic Development

STATE MEDICAL BOARD

550 West Seventh Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Main: 907.269.8163
Fax: 907.269.8196

April 13, 2015

MED S 6736

ANNA WILDY KAMINSKI
PPGNW
4001 LAKE OTIS PARKWAY, #101
ANCHORAGE AK 99508

Dear Licensee:

Our records indicate that you have not renewed your license to practice medicine in the State of Alaska. This license lapsed December 31, 2014. You may not practice in the State of Alaska with a lapsed license. In addition, there is no grace period for practicing with a lapsed license.

If it is not your intent to renew your license, there is no need to respond to this letter. (This is a computer generated letter, if you have already notified this office that it is not your intent to renew, you may disregard this letter)

However, if you do intend to renew your license and have NOT submitted your renewal application, please send the following items:

- Renewal application
- Fees
- All documents that are requested on your particular renewal application
- FSMB Board Action report (MD, DO, DPM, PA)
- Proof of CME's (MD, DO, DPM, MICP)

Renewal application can be located at:

<http://commerce.alaska.gov/dnn/cbpl/ProfessionalLicensing/StateMedicalBoard.aspx>

Thank you for your time and attention to this matter,

Mary R. Sikes
Medical Licensing Examiner (A-K)
mary.sikes@alaska.gov
State of Alaska Medical Board
(907) 465-2756
(907) 465-2974 fax
<http://commerce.alaska.gov/cbpl/pl>

Sikes, Mary R (CED)

From: Sikes, Mary R (CED)
Sent: Friday, April 10, 2015 12:59 PM
To: 'Anna Kaminski'
Subject: RE: Oregon License Application
Attachments: Scanned from Commerce Xerox multifunction device.pdf

Good Afternoon,
These items are being mailed to the Oregon Medical Board today.

Have a great day

Mary R. Sikes

**Please be aware that the application process can take up to 12 weeks or longer in certain instances.
**US mail can take a minimum of 10 business days to reach my desk
***If you are using a third party vendor to process your application, please be aware that you are
COMPLETELY RESPONSIBLE for ALL information that is issued on your behalf*

Medical Licensing Examiner (A-K)
mary.sikes@alaska.gov
State of Alaska Medical Board
Corporations, Business and Professional Licensing
P.O. Box 110806
Juneau AK 99811-0806
(907) 465-2756
(907) 465-2974 fax



ProfessionalLicense.Alaska.Gov/StateMedicalBoard
State of Alaska Medical Board

From: Anna Kaminski [mailto:akaminski@zoomcare.com]
Sent: Friday, March 20, 2015 8:41 AM
To: Sikes, Mary R (CED)
Subject: Re: Oregon License Application

Thank you so much, Ms. Sikes.

Let me be sure I have this-

I will write and send a letter requesting a copy of all records on file be sent to Oregon State Board.

You will let me know about the cost which I will provide and then you are able to send a certified copy.

I do not need to certify this letter, correct?

Anna Kaminski MD

On Thu, Mar 19, 2015 at 3:45 PM, Sikes, Mary R (CED) <mary.sikes@alaska.gov> wrote:

Good Afternoon,

If you are asking for a certified copy of your file sent directly to the Oregon medical board, the fee is \$.25 per page and we require a written request.

After the copy of your file is prepared, you are contacted with the total amount due. When payment is received the certified copy of the file is sent.

If you are asking for verification of licensure, please complete and return the attached form with the fee.

Please be aware, your license file contains only a few certificates.

Mary R. Sikes

**Please be aware that the application process can take up to 12 weeks or longer in certain instances.*

***US mail can take a minimum of 10 business days to reach my desk*

****If you are using a third party vendor to process your application, please be aware that you are COMPLETELY RESPONSIBLE for ALL information that is issued on your behalf*

Medical Licensing Examiner (A-K)

mary.sikes@alaska.gov

State of Alaska Medical Board

Corporations, Business and Professional Licensing

P.O. Box 110806
Juneau AK 99811-0806

[\(907\) 465-2756](tel:(907)465-2756)

[\(907\) 465-2974](tel:(907)465-2974) fax



ProfessionalLicense.Alaska.Gov/StateMedicalBoard

State of Alaska Medical Board

From: Anna Kaminski [<mailto:akaminski@zoomcare.com>]

Sent: Wednesday, March 18, 2015 12:20 PM

To: Sikes, Mary R (CED)

Subject: Oregon License Application

Dear Ms. Sikes,

I am applying for licensure in Oregon. Since my application was complete for Alaska I moved out of my residence. During that time I misplaced many personal records including Diplomas, Birth Certificate and residency completion information.

The state of Oregon has an expedited licensing process. They will accept the credentialing materials form another state.

I am respectfully requesting Alaska records to be sent to allow me to proceed to licensing in a timely fashion. I am in the process of recovering many of these records but the time delay has been significant.

I would be deeply grateful if all documentation could be copied and sent to Oregon. I would expect that there is a fee attached to this service and await your reply.

Sincerely,

Anna Kaminski MD MS

Washington State Medical Director

t: 206-799-1268 | **e:** akaminski@zoomcare.com | **w:** www.zoomcare.com

Follow ZoomCare: ☐ ☐ ☐ ☐

--

Anna Kaminski MD MS

Washington State Medical Director

t: 206-799-1268 | **e:** akaminski@zoomcare.com | **w:** www.zoomcare.com

Follow ZoomCare: ☐ ☐ ☐ ☐

Sikes, Mary R (CED)

Med S 6736

From: Anna Kaminski <akaminski@zoomcare.com>
Sent: Wednesday, March 18, 2015 12:20 PM
To: Sikes, Mary R (CED)
Subject: Oregon License Application

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Ms. Sikes,

I am applying for licensure in Oregon. Since my application was complete for Alaska I moved out of my residence. During that time I misplaced many personal records including Diplomas, Birth Certificate and residency completion information.

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Sincerely,

Anna Kaminski MD MS

Washington State Medical Director

t: 206-799-1268 | **e:** akaminski@zoomcare.com | **w:** www.zoomcare.com

Follow ZoomCare: ☐ ☐ ☐ ☐

Max throw 5 pages Charge

3/26/15

TO: Mary Sikes
State of Alaska Medical Board
Corporations, Business and Professional Licensing
P.O. Box 110806
Juneau AK 99811-0806

FROM: Anna Kaminski MD MS
Washington State Medical Director
ZoomCare
t: 206-799-1268 | e: akaminski@zoomcare.com | w: www.zoomcare.com

Dear Ms Sikes,

I am applying for licensure in Oregon as part of my physician executive job for ZoomCare, LLC with headquarters in Portland, OR. I have lost several documents including diplomas, birth certificates and residency certification. I have been able to replace several but some are up to 3 months.

Oregon will honor licensing materials from ALaska Medical Board. I am requesting that any materials in my files be copied and sent certified to the Oregon Medical Board. I understand you will contact me with the fees for copying and sending.

Thank you in advance for this help. I await the invoice.

Yours,

Anna Kaminski MD





THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

**Department of Commerce, Community,
and Economic Development**

STATE MEDICAL BOARD

550 West Seventh Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Main: 907.269.8163
Fax: 907.269.8196

CERTIFICATION

I, **Crystal Dooley**, Licensing Examiner, Division Corporations, Business and Professional Licen
Department of Commerce, Community and Economic Development, State of Alaska, certify tha
the keeper of the records of the **STATE MEDICAL BOARD** and that these records indicate tha
the following individual is/was licensed as shown:

Name: **ANNA WILDY KAMINSKI**

License Type: **WITH A TEMPORARY PERMIT TO PRACTICE MEDICINE**

License Number: **5333**

Date Originally Issued: **08/27/2009**

Expiration Date: **02/27/2010**

Date of Birth: **05/22/1959**

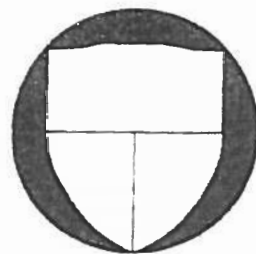
Comments: There is no derogatory information on file regarding this license.

Dated this **Sixth day of April, 2015**

SEAL

A handwritten signature in cursive script, appearing to read "Crystal Dooley", written over a horizontal line.
Crystal Dooley
Licensing Examiner

American Board of Family Medicine



Anna Wildy Kaminski, M.D.

is a Diplomate of this Board and
having met its continuing requirements is hereby

Recertified

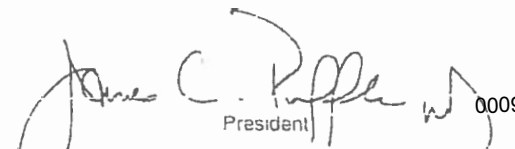
as a

Diplomate

2007-2014


Chair




President 0009

05/26/2017

Group Health Cooperative of Puget Sound

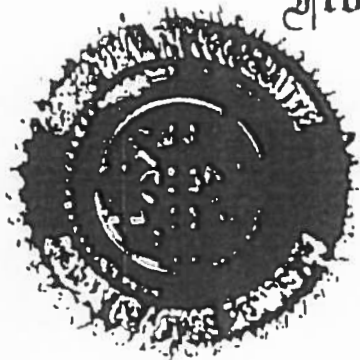
Seattle, Washington

An approved residency in family practice affiliated with the
University of Washington School of Medicine
Be it Known that

Anna Wildy Kaminski, M.D.

Has satisfactorily completed a Residency in Family Practice

From June 25, 1990 To June 30, 1993



In certification we affix hereto our signatures
and the seal of the cooperative on this

30 Day of June 1993

Shi M. Delmon, M.D.

President and Chief Executive Officer

A.L. Tuscott, MD

Medical Director

M.J. Wender, MD

Residency Director

University of California

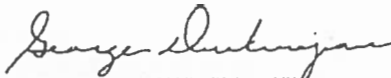
ON THE NOMINATION OF THE FACULTY OF THE SCHOOL OF MEDICINE
HAVE CONFERRED UPON

CERTIFIED TRUE COPIES

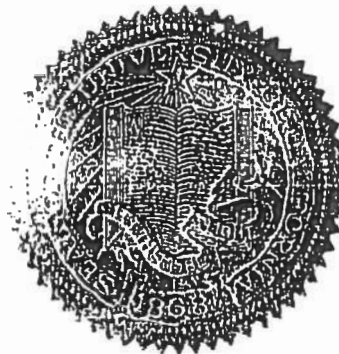
To obtain a certified true copy, take the original document to a notary public so he/she may compare the original to the photocopy of the document. The notary must write "I certify this to be a true copy of the original document" on the photocopy and attest to the fact by signing and notarizing the document.

ANNA WILDY KAMINSKI

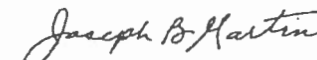
THE DEGREE OF DOCTOR OF MEDICINE
ALL THE RIGHTS AND PRIVILEGES THERETO PERTAINING
AN FRANCISCO THIS SEVENTEENTH DAY OF JUNE IN THE YEAR
NINETEEN HUNDRED AND NINETY.


GOVERNOR OF CALIFORNIA AND
PRESIDENT OF THE REGENTS


PRESIDENT OF THE UNIVERSITY




CHANCELLOR AT SAN FRANCISCO


DEAN OF THE SCHOOL

3672303



State of Alaska
 Department of Commerce, Community, and Economic Development
 Division of Occupational Licensing
 P.O. Box 110806
 Juneau, Alaska 99811-0806
 Telephone: (907) 465-2550
 Fax: (907) 465-2974
 E-mail: license@alaska.gov
 Website: www.commerce.state.ak.us/occ

RECEIVED
 Juneau

APR 01 2015

Division of Corporations, Business
 and Professional Licensing

✓ 20 CAL

REQUEST FOR LICENSE VERIFICATION

To request an official signed and sealed document verifying your Alaska license, certification, or registration to be sent to another state or agency, please complete this form and submit it along with the **\$20.00 verification fee** to the address listed above. Make checks payable to "State of Alaska." If you would like the verification returned by express courier, please submit a prepaid addressed envelope. Requests are generally processed within 10 to 14 days of receipt.

PROFESSION: Physician

License Number: No. 6736 License Type: Physician

Is license current? ☐ Yes ☒ No License Expiration Date: 12/31/2014

Name: Kaminski Anna W
Last First Middle

Mailing Address: 523 N. 48th St
Street
Seattle WA 98103
City State Zip Code

Is this a change of address? ☒ Yes ☐ No

Provide Name and Address of agency receiving license verification: (\$20.00 per mailing)

(1) Oregon Medical Board
1500 SW 1st Ave. Suite 620
Portland, OR 97201-5847

(2) Att: App # 169953

Anderson MD
 Signature

3/26/15
 Date



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

Department of Commerce, Community,
and Economic Development

STATE MEDICAL BOARD

550 West Seventh Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Main: 907.269.8163
Fax: 907.269.8196

CERTIFICATION

I, **Crystal Dooley**, Licensing Examiner, Division Corporations, Business and Professional Licen
Department of Commerce, Community and Economic Development, State of Alaska, certify tha
the keeper of the records of the **STATE MEDICAL BOARD** and that these records indicate tha
the following individual is/was licensed as shown:

Name: **ANNA WILDY KAMINSKI**

License Type: **PHYSICIAN**

License Number: **6736**

Date Originally Issued: **10/28/2009**


Expiration Date: **12/31/2014**

Date of Birth: **05/22/1959**

Comments: There is no derogatory information on file regarding this license.

Dated this **Sixth day of April, 2015**

SEAL


Crystal Dooley
Licensing Examiner

CERTIFICATION

I, **Crystal Dooley**, Licensing Examiner, Division Corporations, Business and Professional Licenses, Department of Commerce, Community and Economic Development, State of Alaska, certify that I am the keeper of the records of the **STATE MEDICAL BOARD** and that these records indicate that the following individual is/was licensed as shown:

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License Type: **WITH A TEMPORARY PERMIT TO PRACTICE MEDICINE**

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Date of Birth: **05/22/1959**

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Comments: There is no derogatory information on file regarding this license.

Dated this **Sixth day of April, 2015**

SEAL

Crystal Dooley
Licensing Examiner

No. 6736

Effective: 11/05/2012

Expires: 12/31/2014

STATE OF ALASKA

DEPARTMENT OF COMMERCE, COMMUNITY, & ECONOMIC DEVELOPMENT

Division of Corporations, Business and Professional Licensing

STATE MEDICAL BOARD

Certifies that

ANNA WILDY KAMINSKI

IS A LICENSED

PHYSICIAN

Commissioner: Susan K. Bell

Wallet Card

No. 6736		State Of Alaska	
Department of Commerce, Community, and Economic Development Division of Corporations, Business and Professional Licensing			
ANNA WILDY KAMINSKI			
IS A LICENSED PHYSICIAN			
Effective 11/05/2012	Expiration 12/31/2014	Date of Birth 05/22/1959	
Signature _____			

IT IS YOUR RESPONSIBILITY TO BE AWARE OF THE CONTINUING EDUCATION REQUIREMENTS FOR RENEWAL AND REPORTING REQUIREMENTS FOR MALPRACTICE SETTLEMENTS.

WALL CERTIFICATES SUITABLE FOR FRAMING ARE AVAILABLE FOR A FEE OF \$20.

THE FEE FOR VERIFICATIONS OF LICENSURE OR LETTERS OF GOOD STANDING IS \$20.

PER 12 AAC 02.900 YOU MUST NOTIFY US IN WRITING IF YOU CHANGE YOUR MAILING ADDRESS. YOU MAY FAX YOUR ADDRESS CHANGE TO (907) 465-2974.

Division website: <http://www.commerce.alaska.gov/occ>

Division e-mail: license@alaska.gov

MED

ANCHORAGE AK 99508
4001 LAKE OTIS PARKWAY, #101
PPGNW
ANNA WILDY KAMINSKI

STATE MEDICAL BOARD

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
P.O. Box 110806, Juneau, Alaska 99811-0806
Physician - Biennial License Renewal
January 1 2013 - December 31 2014

**Online
Renewal**

Personal Information:

Name KAMINSKI ANNA WILD' License MEDS6736

Address of Record

PPGNW
4001 LAKE OTIS PARKWAY, #101
ANCHORAGE AK 99506

Alternate Address

523 NORTH 38TH STREET
SEATTLE WA 98103

Spec FAMILY PRACTICE Phone 206-328-7722 Fax 206-720-4657
States Washington Email anna.kaminski@ppgnw.org

Web Information:

Receipt 10146578
Auth Code 056617

Web Date 11/05/12
Web Total

XID
Successful Y

Only the license holder is authorized to renew their license on-line. USE OF THE ON-LINE PROGRAM BY ANYONE OTHER THAN THE LICENSEE IS PROHIBITED. WARNING: It is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

By checking this box, I affirm that I am the licensee applying for the renewal of this license and that I understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

YES

Professional Fitness Questions

- 1 Since the date of your last application for a license in Alaska or within the past two years has your professional license been denied, revoked, suspended, surrendered, fined, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction (including Alaska), including military authorities, or is any such action pending? NO
- 1 Since the date of your last application for a license in Alaska or within the past two years has your professional license been denied, revoked, suspended, surrendered, fined, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction (including Alaska), including military authorities, or is any such action pending? NO
- 2 Since the date of your last application for a license in Alaska or within the past two years have you voluntarily or involuntarily surrendered or restricted your professional license in any jurisdiction for any reason or is any such action pending? NO
- 2 Since the date of your last application for a license in Alaska or within the past two years have you voluntarily or involuntarily surrendered or restricted your professional license in any jurisdiction for any reason or is any such action pending? NO
- 3 Since the date of your last application for a license in Alaska or within the past two years have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (for other than late medical records) or is any such action pending? NO
- 3 Since the date of your last application for a license in Alaska or within the past two years have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (for other than late medical records) or is any such action pending? NO
- 4 Since the date of your last application for a license in Alaska or within the past two years have you been convicted of a felony or misdemeanor, including but not limited to, a conviction involving driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. Convicted includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine. NO
- 4 Since the date of your last application for a license in Alaska or within the past two years have you been convicted of a felony or misdemeanor, including but not limited to, a conviction involving driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. Convicted includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine. NO
- 5 Since the date of your last application for a license in Alaska or within the past two years have you been the subject of an investigation by any licensing jurisdiction or are you currently under investigation by any licensing jurisdiction or is any such action pending? NO

- | | | |
|----|--|----|
| 5 | Since the date of your last application for a license in Alaska or within the past two years have you been the subject of an investigation by any licensing jurisdiction or are you currently under investigation by any licensing jurisdiction or is any such action pending? | NO |
| 6 | Since the date of your last application for a license in Alaska or within the past two years have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under inquiry or investigation? | NO |
| 6 | Since the date of your last application for a license in Alaska or within the past two years have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under inquiry or investigation? | NO |
| 7 | Since the date of your last application for a license in Alaska or within the past two years have you been notified of any complaint or allegations involving you, filed with or by any licensing authority, including Alaska, which complaint or allegations remain open as of the date of this application? | NO |
| 7 | Since the date of your last application for a license in Alaska or within the past two years have you been notified of any complaint or allegations involving you, filed with or by any licensing authority, including Alaska, which complaint or allegations remain open as of the date of this application? | NO |
| 8 | Since the date of your last application for a license in Alaska or within the past two years have you experienced, been diagnosed with, been evaluated for, or treated for any alcohol or other chemical abuse, dependency, or impairment? | NO |
| 8 | Since the date of your last application for a license in Alaska or within the past two years have you experienced, been diagnosed with, been evaluated for, or treated for any alcohol or other chemical abuse, dependency, or impairment? | NO |
| 9 | Since the date of your last application for a license in Alaska or within the past two years have you experienced, been diagnosed with, been evaluated for, or treated for any physical or mental condition which may impair or interfere with your ability to safely practice medicine? | NO |
| 9 | Since the date of your last application for a license in Alaska or within the past two years have you experienced, been diagnosed with, been evaluated for, or treated for any physical or mental condition which may impair or interfere with your ability to safely practice medicine? | NO |
| 10 | Since the date of your last application for a license in Alaska or within the past two years have you experienced, been diagnosed with, been evaluated for, or treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder? | NO |
| 10 | Since the date of your last application for a license in Alaska or within the past two years have you experienced, been diagnosed with, been evaluated for, or treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder? | NO |
| 11 | Since the date of your last application for a license in Alaska or within the past two years has a medical malpractice claim been resolved or a civil action been terminated in which damages have been paid or are to be paid by you or on your behalf to a claimant or plaintiff, whether by judgment or under settlement? | NO |
| 11 | Since the date of your last application for a license in Alaska or within the past two years has a medical malpractice claim been resolved or a civil action been terminated in which damages have been paid or are to be paid by you or on your behalf to a claimant or plaintiff, whether by judgment or under settlement? | NO |
| 12 | If you responded yes to question 11, has such settlement already been reported to the board? | NO |
| 12 | If you responded yes to question 11, has such settlement already been reported to the board? | NO |
| 13 | Since the date of your last application for a license in Alaska or within the past two years have you been investigated or disciplined by the Drug Enforcement Administration or have you surrendered your federal or any state controlled substance registration for any reason or is any such action pending? | NO |
| 13 | Since the date of your last application for a license in Alaska or within the past two years have you been investigated or disciplined by the Drug Enforcement Administration or have you surrendered your federal or any state controlled substance registration for any reason or is any such action pending? | NO |

Continuing Education Questions

- CE1 I hereby affirm that I have been awarded the required CME and have complied with the continuing medical education requirements set forth in regulations 12 AAC 40.200-240 for the license period 01/01/2011 through 12/31/2012.
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No. 6736

Effective: 11/01/2010

Expires: 12/31/2012

STATE OF ALASKA

DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT

Division of Corporations, Business and Professional Licensing

P.O. Box 110806, Juneau, Alaska 99811-0806

STATE MEDICAL BOARD

Certifies that

ANNA WILDY KAMINSKI

IS A LICENSED

PHYSICIAN

Commissioner: Susan K. Bell

Wallet Card

No. 6736

State Of Alaska

Department of Commerce, Community, and Economic Development

Division of Corporations, Business and Professional Licensing

ANNA WILDY KAMINSKI

IS A LICENSED
PHYSICIAN

Effective

11/01/2010

Expiration

12/31/2012

Date of Birth

05/22/1959

Signature _____

IT IS YOUR RESPONSIBILITY TO BE AWARE OF
CONTINUING EDUCATION REQUIREMENTS FOR
RENEWAL.

WALL CERTIFICATES SUITABLE FOR FRAMING
ARE AVAILABLE FOR A FEE OF \$20.

THE FEE FOR VERIFICATIONS OF LICENSURE OR
LETTERS OF GOOD STANDING IS \$20.

PER 12 AAC 02.900 YOU MUST NOTIFY US IN
WRITING IF YOU CHANGE YOUR MAILING
ADDRESS. YOU MAY FAX YOUR ADDRESS
CHANGE TO (907) 465-2974.

Division Website: www.commerce.state.ak.us/occ

MED

ANCHORAGE AK 99508
4001 LAKE OTIS PARKWAY, #101
PPGNW
ANNA WILDY KAMINSKI

STATE MEDICAL BOARD

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
P.O. Box 110806, Juneau, Alaska 99811-0806
Physician - Biennial License Renewal
January 1 2011 - December 31 2012

**Online
Renewal**

Personal Information:

Name KAMINSKI ANNA WILD'

License MEDS6736

Address of Record

PPGNW

4001 LAKE OTIS PARKWAY, #101
ANCHORAGE AK 9950E

Alternate Address

523 N. 48TH ST

SEATTLE WA 98103

Spec FAMILY PRACTICE

Phone 206-328-7722

Fax 206-720-4657

States Washington

Email anna.kaminski@ppgnw.org

Web Information:

Receipt 6613844

Web Date 11/01/10

XID 82011030500497

Auth Code 072829

Web Total

Successful Y

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By checking this box, I affirm that I am the licensee applying for the renewal of this license and that I understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

YES

Professional Fitness Questions

- 1 Has your professional license been denied, revoked, suspended, surrendered, fined, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction (including Alaska), including military authorities, or is any such action pending? NO
- 1 Has your professional license been denied, revoked, suspended, surrendered, fined, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction (including Alaska), including military authorities, or is any such action pending? NO
- 2 Have you voluntarily or involuntarily surrendered or restricted your professional license in any jurisdiction for any reason or is any such action pending? NO
- 2 Have you voluntarily or involuntarily surrendered or restricted your professional license in any jurisdiction for any reason or is any such action pending? NO
- 3 Have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (for other than late medical records) or is any such action pending? NO
- 3 Have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (for other than late medical records) or is any such action pending? NO
- 4 Have you been convicted of a felony or misdemeanor, other than minor traffic violations, under the laws of any local, state, or federal jurisdiction of the United States or any other country or is any such action pending? NO
- 4 Have you been convicted of a felony or misdemeanor, other than minor traffic violations, under the laws of any local, state, or federal jurisdiction of the United States or any other country or is any such action pending? NO
- 5 Have you been the subject of an investigation by any licensing jurisdiction or are you currently under investigation by any licensing jurisdiction or is any such action pending? NO
- 5 Have you been the subject of an investigation by any licensing jurisdiction or are you currently under investigation by any licensing jurisdiction or is any such action pending? NO
- 6 Have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under inquiry or investigation? NO
- 6 Have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under inquiry or investigation? NO
- 7 Have you been notified of any complaint or allegations involving you, filed with or by any licensing authority, including Alaska, which complaint or allegations remain open as of the date of this application? NO
- 7 Have you been notified of any complaint or allegations involving you, filed with or by any licensing authority, including Alaska, which complaint or allegations remain open as of the date of this application? NO
- 8 Have you experienced, been diagnosed with, been evaluated for, or treated for any alcohol or other chemical abuse, dependency, or impairment? NO

05/26/2017

0020

523 N. 48TH ST

SEATTLE WA 98103

- | | | |
|----|---|----|
| 8 | Have you experienced, been diagnosed with, been evaluated for, or treated for any alcohol or other chemical abuse, dependency, or impairment? | NO |
| 9 | Have you experienced, been diagnosed with, been evaluated for, or treated for any physical or mental condition which may impair or interfere with your ability to safely practice medicine? | NO |
| 9 | Have you experienced, been diagnosed with, been evaluated for, or treated for any physical or mental condition which may impair or interfere with your ability to safely practice medicine? | NO |
| 10 | Have you experienced, been diagnosed with, been evaluated for, or treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder? | NO |
| 10 | Have you experienced, been diagnosed with, been evaluated for, or treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder? | NO |
| 11 | Has a medical malpractice claim been resolved or a civil action been terminated in which damages have been paid or are to be paid by you or on your behalf to a claimant or plaintiff, whether by judgment or under settlement? | NO |
| 11 | Has a medical malpractice claim been resolved or a civil action been terminated in which damages have been paid or are to be paid by you or on your behalf to a claimant or plaintiff, whether by judgment or under settlement? | NO |
| 12 | If you responded | NO |
| 12 | If you responded | NO |
| 13 | Have you been investigated or disciplined by the Drug Enforcement Administration or have you surrendered your federal or any state controlled substance registration for any reason or is any such action pending? | NO |
| 13 | Have you been investigated or disciplined by the Drug Enforcement Administration or have you surrendered your federal or any state controlled substance registration for any reason or is any such action pending? | NO |

Continuing Education Questions

- CE1 I hereby affirm that I have been awarded the required CME and have complied with the continuing medical education requirements set forth in regulations 12 AAC 40.200-240 for the license period 01/01/2009 through 12/31/2010.
- CE1 I hereby affirm that I have been awarded the required CME and have complied with the continuing medical education requirements set forth in regulations 12 AAC 40.200-240 for the license period 01/01/2009 through 12/31/2010.

No. 6736
Effective: 10/28/2009
Expires: 12/31/2010

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC
DEVELOPMENT
Division of Corporations, Business and Professional Licensing
STATE MEDICAL BOARD

Certifies that
ANNA WILDY KAMINSKI
IS A LICENSED
PHYSICIAN

Commissioner: Emil Notti

Wallet Card

No. 6736
State Of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

ANNA WILDY KAMINSKI

IS A LICENSED
PHYSICIAN

Effective	Expiration	Date of Birth
10/28/2009	12/31/2010	05/22/1959

Signature _____

IT IS YOUR RESPONSIBILITY TO BE AWARE OF
THE CONTINUING EDUCATION REQUIREMENTS
FOR RENEWAL.

WALL CERTIFICATES SUITABLE FOR FRAMING
ARE AVAILABLE FOR A FEE OF \$20.

THE FEE FOR VERIFICATIONS OF LICENSURE
OR LETTERS OF GOOD STANDING IS \$20.

PER 12 AAC 02.900 YOU MUST NOTIFY US IN
WRITING IF YOU CHANGE YOUR MAILING
ADDRESS. YOU MAY FAX YOUR ADDRESS
CHANGE TO (907) 465-2974.

Division Website: www.commerce.state.ak.us/occ

MED

ANNA WILDY KAMINSKI
C/O PLANNED PARENTHOOD
3231 GLACIER HWY
JUNEAU AK 99801



ALASKA STATE MEDICAL BOARD
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
(333 Willoughby Avenue – Ninth Floor)
P.O. Box 110806, Juneau, Alaska 99811-0806
(907) 465-2756 A – K or (907) 465-2541 L – Z
E-mail: License@commerce.state.ak.us

FINAL BOARD ACTION

Kaminski, Anna Wildy
PHYSICIAN APPLICANT'S NAME (Last, First, Middle)

☒ MD ☐ DO ☐ DPM

APPROVAL TO GRANT A PERMANENT, UNRESTRICTED LICENSE

At a regularly scheduled meeting of the Alaska State Medical Board, the board examined the credentials and verifications submitted by and provided on behalf of the physician applicant named above. Following careful consideration, the board determined that the applicant has met the qualifications for a medical license in this state; and therefore, the board voted to grant to this physician a permanent and unrestricted license to practice medicine.

PENDING: ☐ Fees ☐ NPDB Report ☐ Other _____

Signature, Board Member: _____ Date: Oct 22-23/07

APPROVAL TO GRANT A LICENSE WITH CONDITIONS

At a regularly scheduled meeting of the Alaska State Medical Board, the board examined the credentials and verifications submitted by and provided on behalf of the physician applicant named above. Following careful consideration, the board determined that the applicant has met the qualifications for a medical license in this state; and therefore, the board voted to grant a permanent license to practice medicine to the above named physician with the following conditions:

Conditions of Licensure: _____

Signature, Board Member: _____ Date: _____

LICENSE APPLICATION DENIED

At a regularly scheduled meeting of the Alaska State Medical Board, the board examined the credentials and verifications submitted by and provided on behalf of the physician applicant named above. Following careful consideration, the board voted to deny a permanent license to practice medicine to the applicant physician for the following reason(s):

Basis for Denial: _____

Signature, Board Member: _____ Date: _____

For Staff Use Only: License Issue Date: 10.28.09 License No.: 6736 By: MMB
Application Referred to: _____ for MOA or _____
Notice of board action to: _____ Paralegal: _____ FSMB Report Submitted: _____ NPDB Report: _____ Other: _____

No. 5333

Effective: 08/27/2009

Expires: 02/27/2010

STATE OF ALASKA

DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC
DEVELOPMENT

Division of Corporations, Business and Professional Licensing

STATE MEDICAL BOARD

Certifies that

ANNA W KAMINSKI

IS A PHYSICIAN

WITH A TEMPORARY PERMIT TO PRACTICE MEDICINE

VALID FOR SIX MONTHS FROM 8/27/2009

Commissioner: Emil Notti

Wallet Card

No. 5333	State Of Alaska	
Department of Commerce, Community, and Economic Development Division of Corporations, Business and Professional Licensing		
ANNA W KAMINSKI		
IS A PHYSICIAN		
WITH A TEMPORARY PERMIT TO PRACTICE MEDICINE		
Effective	Expiration	Date of Birth
08/27/2009	02/27/2010	05/22/1959
VALID FOR SIX MONTHS FROM 8/27/2009		
Signature _____		

Per 12 AAC 02.900 you must notify our office in writing if you change your mailing address. You may fax your address change to (907) 465-2974.

MED

ANNA W KAMINSKI
C/O PLANNED PARENTHOOD
3231 GLACIER HWY
JUNEAU AK 99801



STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Division of Corporations, Business and Professional Licensing

Sean Parnell, Governor
Emil Notti, Commissioner
Lynne Smith, Director

ALASKA LICENSE APPLICATION
STATUS REPORT

July 30, 2009

Anna Wildy Kaminski, MD
C/O Planned Parenthood
3231 Glacier Hwy
Juneau, AK 99801

Dear Dr. Kaminski:

Your application file is under review by the board's executive administrator for the next step in the process: document verification and approval. With the administrator's approval, a temporary permit may be issued to you. This aspect of the process may take up to three weeks from the date of this letter. The temporary permit will be mailed to you. You may also check the board's website (www.commerce.state.ak.us/occ/pmed.htm) and click on 'occupational license search' to verify that the permit has been issued.

If there were any 'yes' responses in your application or any adverse or derogatory information contained in your file, the review process will take longer. In this event, either the executive administrator or a board investigator will contact you directly.

If your file is reviewed and a temporary permit approved for issuance, your application file will be presented to the medical board for consideration at its next regularly scheduled meeting. The board will review your application and all associated documents. Upon the recommendation of the board, and assuming all fees have been paid, a permanent license will be issued following the board meeting. The next regularly scheduled meeting of the Alaska State Medical Board will be: **October 22-23, 2009.** We understand that you are anxious to receive your permit or license and appreciate your continued cooperation and patience.

Sincerely,

Mariana Moreno-Goodwin
Licensing Examiner
Alaska State Medical Board

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
P.O. BOX 110806
JUNEAU, ALASKA 99811-0806
E-mail: license@commerce.state.ak.us

Anna W. Kaminski, MD
 2001 East Madison
 Seattle WA 98122

Date: 4-27-09

Your application for licensure to practice medicine and surgery in the State of Alaska has been received by the Alaska State Medical Board. To further process your application, the items checked below are needed.

- _____ 1. Completed Application _____
- _____ 2. Authorization to release records form.
- _____ 3. Nonrefundable Application fee of \$250. We received \$ _____. Please remit remaining fee of \$ _____
- _____ 4. The license fee is \$590. We received \$ _____. Please remit remaining fee of \$ _____. Please note the full fee may be submitted now or just \$145 which will cover the issuance of a temporary license. The remainder of the licensing fee may be submitted now or when the board approves your application.
- _____ 5. Examination scores requested directly from: FLEX _____ NBME _____ USMLE _____
 State of _____ Puerto Rico _____ LLMC _____ NBOME _____ NBPME _____
- ✓ 4/11/09 6. Certified true copy of your medical school diploma (notary public must state "true copy of original," sign and seal) or original transcript sent directly from the medical school.
- ✓ Rec 4/1/09 7. Certified true copy of graduate training program certificate(s) for postgraduate year(s) 1. Notary public must state "true copy of original," sign and seal certificate or provide original letter on letterhead sent directly from the program. If you graduated from medical school before January 1, 1995, you must verify completion of the first year of postgraduate training OR if you graduated from medical school on or after January 1, 1995, you must certify completion of the first two years of postgraduate training. Foreign-trained graduates must provide proof of the first three years of postgraduate training in the United States regardless of the year of graduation.
- ✓ 4/15/09 8. Verification of Medical/Osteopathic School Education.
- _____ 9. Verification of Postgraduate Training for year(s) _____ sent directly from program(s) attended.
- ✓ 4/27/09 10. Verification of license(s) in WA both licenses (1) 5/1/09 Lic 00030198
- ✓ 4/27/09 11. Hospital privileges information needed from both listed
- _____ 12. AMA Profile _____ AOA Profile _____ DEA Clearance _____ Federation Clearance _____

Additional Comments: _____

Linda Sherwood, Licensing Examiner
 (907) 465-2541
 Alaska State Medical Board



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

MEDICAL QUALITY ASSURANCE COMMISSION

July 22, 2009

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

State of Alaska
POB 110806
Juneau AK 99811

Subject: Credential Verification

To Whom It May Concern:

This will verify the status of the Physician And Surgeon Residency License for /Dr. ANNA KAMINSKI.

Sections may be blank because the information is not in our database or is not applicable for this credential type.

Year of Birth:	05/22/1959
Credential Number:	MDRE.ML.20003269
Credential Type:	Physician And Surgeon Residency License
Current Credential Status:	EXPIRED LEGACY
First Credential Date:	06/25/1990
Expiration Date:	07/31/1992
Last Renewal Date:	
Examination:	
Exam Level:	
Score:	

Our records above show that the licensee has not been disciplined, the licensee is considered in good standing

Please call me at (360) 236-2766 if you have questions or visit our Online Provider Credential Search at www.doh.wa.gov.



Betty Elliott

Betty Elliott, Customer Service Specialist 2

July 22, 2009

To: Alaska State Medical Board


Att: Mariana Moreno-Goodwin

Re: Anna Kaminski, MD Alaska State License Application

The application submitted to you June 2009 inaccurately lists my hospital affiliations. I apologize for this omission which I should have caught before mailing.

I have worked in an outpatient setting since 10/2002. I did not renew any privileges following that date and have not applied or been denied or revoked since then. The documentation on page 4 Q.21 line 2 was not completed. It should read "From 8/1995 To 8/1995" due to a hospital merger.

I am submitting a corrected form. I apologize for the confusion caused by my not clearly reviewing the form requirements regarding hospital credentials in the last five years.

 MD
Anna Kaminski MD.

19. Other Professional Licensure

Other than as a physician, have you ever been licensed in any jurisdiction in any other profession of the healing arts?

☒ No

☐ Yes

If Yes, please complete the following:

Profession (DDS, DC, RN, PA-C, DC, etc.)	Jurisdiction (State, territory, country, etc.)	Date Licensed	Was License Disciplined?
			<input type="checkbox"/> No <input type="checkbox"/> Yes
			<input type="checkbox"/> No <input type="checkbox"/> Yes

If you have responded 'yes' to question 19, verifications of good standing for each license must be submitted for all other health care professions under which you have been licensed by those jurisdictions.

20. Medical Societies and Professional Organizations

Name of Organization	Address	Date From/To - YYYY
Association of Reproductive Health Professionals	1330 Broadway, Oakland, CA 94612	10/2006 - current
Physicians for Reproductive Choice and Health	55 W 34th St NYC NY 10018	2007 - current
Medical Students for choice	PO Box 40188 Philadelphia, PA 19106	2005 - 2007
American Association of University Women		2000 - 2005

21. Hospital Affiliations

Have you ever held hospital privileges?

☒ Yes

☐ No

If Yes, please list all hospitals in which you have been credentialed within the immediate past five years.

HOSPITAL	MAILING ADDRESS	WHEN PRIVILEGED (MM/YYYY)
1 Virginia Mason Clinic	1100 9th Ave Seattle, WA 98101	From 10/1994 To 2/2002
2 Swedish Medical Center	747 Broadway Seattle, WA 98122-4307	From 8/1995 To
3 Group Health	200 15 Ave E	From 6/1993 To 10/1994
4		From To
5		From To
6		From To
7		From To

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

Applicant Name: Anna Kaminski	Date: 2/5/09
-------------------------------	--------------

Kaminski, Anna

From: Moreno-Goodwin, Mariana E (CED) [mariana.moreno-goodwin@alaska.gov]
Sent: Tuesday, June 16, 2009 3:09 PM
To: Kaminski, Anna
Subject: Application status

Dr. Kaminski,

To complete your application the following items are needed:

- WA VOL permit
- Verification of Hosp. privileges for VA Mason Clinic & Swedish Medical

Thank you for your assistance.

Mariana Moreno-Goodwin, Licensing Examiner
Alaska State Medical Board
333 Willoughby Ave State Office Building 9th Floor
Email: mariana.moreno-goodwin@alaska.gov
Office: 907-465-2756
Fax: 907-465-2974

Moreno-Goodwin, Mariana E (CED)

From: Moreno-Goodwin, Mariana E (CED)
Sent: Wednesday, July 22, 2009 1:39 PM
To: 'Anna.Kaminski@ppgnw.org'
Subject: application status

Hello Dr. Kaminski,

Per our telephone conversation, please follow up on your WA verification of licensure for your permit. Also, needed is a new hospital list form to correct Virginia Mason and Swedish. If you did not have privileges and or the privileges are past 5 years ago, please provide a statement to clarify your relationships w/ hospitals.

Thank you for your assistance in completing your file.

Mariana Moreno-Goodwin, Licensing Examiner (A-K)
Alaska State Medical Board
333 Willoughby Ave State Office Building 9th Floor
Juneau AK 99801
Email: mariana.moreno-goodwin@alaska.gov
Office: 907-465-2756
Fax: 907-465-2974

Moreno-Goodwin, Mariana E (CED)

From: Moreno-Goodwin, Mariana E (CED)

Sent: Tuesday, June 16, 2009 2:09 PM

To: 'Anna.Kaminski@ppgnw.org'

Subject: Application status

Dr. Kaminski,

To complete your application the following items are needed:

- WA VOL permit
- Verification of Hosp. privileges for VA Mason Clinic & Swedish Medical

Thank you for your assistance.

Mariana Moreno-Goodwin, Licensing Examiner
Alaska State Medical Board
333 Willoughby Ave State Office Building 9th Floor
Email: mariana.moreno-goodwin@alaska.gov
Office: 907-465-2756
Fax: 907-465-2974



ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Avenue - Ninth Floor)
Post Office Box 110806 Juneau AK 99811-0806
A - K: 907/465-2756 L - Z: 907/465-2541
E-mail: license@commerce.state.ak.us

MD/DO

RECEIVED
JUNEAU

JUN 15 2009

Division of Corporations, Business
and Professional Licensing

VERIFICATION OF MEDICAL/ OSTEOPATHIC SCHOOL EDUCATION

Instructions to the Applicant:

Type or print legibly. Complete Part I below and send to the medical school from which you received your diploma.

PART I

Full Name (Last, First, Middle) Kaminski Anna	Maiden or Other Names Used: W none	Date of Birth (MM/DD/YYYY) 05/22/1959
Mailing Address 2001 E. Madison	City Seattle	State WA
	Zip 98122-2959	
Signature of Applicant 	Date of Signature 3/27/09	

Full Medical School Name UCB/UCSF Joint Medical Program
Location 400 Parnassus Avenue San Francisco CA

FOLLOWING TO BE COMPLETED BY MEDICAL SCHOOL STAFF ONLY

PART II

Instructions to the Medical School: Please complete the information below and return this document directly to the Alaska board at the letterhead address.

Exact Date on School Diploma June 17 1990

During this physician's medical school education, was he/she ever investigated by the school or disciplined by the school for any reason? Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted, or otherwise disciplined.

☒ No

☐ Yes

If you responded "Yes" to this question, please provide a detailed explanation of the action and the reason for the action on a separate sheet of paper attached to this form signed and dated by the person whose signature appears below.

Signed _____

(SEAL, If Applicable)

Printed Name M. Papadakis, MD

Title Associate Dean, Student Affairs

Date June 10, 2009

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
P.O. BOX 110806
JUNEAU, ALASKA 99811-0806
E-mail: license@commerce.state.ak.us

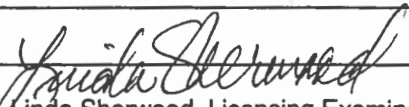
Anna W. Kaminski, MD
2001 East Madison
Seattle WA 98122

Date: 4-27-09

Your application for licensure to practice medicine and surgery in the State of Alaska has been received by the Alaska State Medical Board. To further process your application, the items checked below are needed.

- _____ 1. Completed Application _____
- _____ 2. Authorization to release records form.
- _____ 3. Nonrefundable Application fee of \$250. We received \$_____. Please remit remaining fee of \$_____
- _____ 4. The license fee is \$590. We received \$_____. Please remit remaining fee of \$_____. Please note the full fee may be submitted now or just \$145 which will cover the issuance of a temporary license. The remainder of the licensing fee may be submitted now or when the board approves your application.
- _____ 5. Examination scores requested directly from: FLEX _____ NBME _____ USMLE _____
State of _____ Puerto Rico _____ LLMC _____ NBOME _____ NBPME _____
- ☒ 6. Certified true copy of your medical school diploma (notary public must state "true copy of original," sign and seal) or original transcript sent directly from the medical school.
- ☒ 7. Certified true copy of graduate training program certificate(s) for postgraduate year(s) 1.
Notary public must state "true copy of original," sign and seal certificate or provide original letter on letterhead sent directly from the program. If you graduated from medical school before January 1, 1995, you must verify completion of the first year of postgraduate training OR if you graduated from medical school on or after January 1, 1995, you must certify completion of the first two years of postgraduate training. Foreign-trained graduates must provide proof of the first three years of postgraduate training in the United States regardless of the year of graduation.
- ☒ 8. Verification of Medical/Osteopathic School Education. Requested 4/1
- _____ 9. Verification of Postgraduate Training for year(s) _____ sent directly from program(s) attended.
- ☒ 10. Verification of license(s) in WA both licenses Requested 4/1
- ☒ 11. Hospital privileges information needed from ~~both listed~~ None for >5 years.
All outpt since 1/2002.
- _____ 12. AMA Profile _____ AOA Profile _____ DEA Clearance _____ Federation Clearance _____

Additional Comments: _____


Linda Sherwood, Licensing Examiner
(907) 465-2541
Alaska State Medical Board



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

May 04, 2009

PO BOX 47866
Olympia, WA 98504-7866

State of Alaska
POB 110806
Juneau AK 99811

Subject: Credential Verification

To Whom It May Concern:

This will verify the status of the Physician And Surgeon License for Dr. ANNA KAMINSKI.

Sections may be blank because the information is not in our database or is not applicable for this credential type.

Year of Birth:	05/22/1959
Credential Number:	MD.MD.00030198
Credential Type:	Physician And Surgeon License
Current Credential Status:	ACTIVE IN RENEWAL RENEWAL NOTICE SENT
First Credential Date:	09/15/1992
Expiration Date:	05/22/2009
Last Renewal Date:	
Examination:	
Exam Level:	
Score:	

If our records above show that the licensee has been disciplined, photocopies from the public file are available upon written request. Send request to the Medical Quality Assurance

Please call me at (360) 236-2766 if you have questions or visit our Online Provider Credential Search at www.doh.wa.gov.

Betty Elliott

Betty Elliott, Customer Service Specialist 2





ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Avenue - Ninth Floor)
Post Office Box 110806 Juneau AK 99811-0806
A - K: 907/465-2756 L - Z: 907/465-2541
E-mail: license@commerce.state.ak.us

PGY

RECEIVED
For Office Use Only
JUNEAU

APR 13 2009

Division of Corporations, Business
and Professional Licensing

VERIFICATION OF POSTGRADUATE TRAINING

Instructions to the Applicant:

Type or print legibly. Complete Part I below and send to the post-graduate training program(s) you attended.
NOTE: At least two years of postgraduate training must be verified if the physician graduated from medical school on or after January 1, 1995. Three years of postgraduate training must be verified for international medical school graduates.

PART I

Full Name (Last, First, Middle) Kaminski, Anna W	Maiden or Other Names Used: None	Date of Birth (MM/DD/YYYY) 05/22/1959
Mailing Address 2001 E. Madison	City Seattle	State WA
	Zip 98122-2959	
Medical/Osteopathic School (Name and Location) Group Health Cooperative	Yr of Graduation 1993	If IMG, ECFMG No. n/a
Signature of Applicant <i>Anna W Kaminski MD</i>	Date 3/27/09	

NAME OF POSTGRADUATE PROGRAM

Group Health Cooperative

ADDRESS

FOLLOWING TO BE COMPLETED BY POST-GRADUATE PROGRAM STAFF ONLY

PART II

Post-graduate Training Program: Please complete the information requested below and return this document directly to the Alaska board at the letterhead address.

VERIFICATION FOR:

PG-Yr 1 ☒

PG-Yr 2 ☒

PG-Yr 3 ☒

PG-Yr 4 ☐

PG-Yr 5 ☐

PG-Yr 6 ☐

Exact Dates of Training

6/1990 - 6/1993

- At the time this individual completed training in your program, was the program accredited through the Accreditation Council for Graduate Medical Education or the American Osteopathic Association?
☒ Yes ☐ No
- During the physician's participation in your program, was he/she ever investigated or disciplined by the program, such disciplinary actions to include but not be limited to, being placed on probation, issued a letter of reprimand or warning, censured, suspended from the program, restricted, or otherwise disciplined? If you respond "Yes" to this question, please attach a separate sheet providing a detailed explanation of the action and the reason for the action.
☒ No ☐ Yes
- Is there anything in this physician's postgraduate training records that would indicate he/she would be unable to practice medicine competently and safely? If "Yes", please attach a detailed explanation.
☒ No ☐ Yes

Signature

Printed Name

SARA THOMPSON
SARA THOMPSON

Post-Graduate Training Verification

Date

Title

4/1/09
Program Director





ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Avenue - Ninth Floor)
Post Office Box 110806 Juneau AK 99811-0806
A - K: 907/465-2756 L - Z: 907/465-2541
E-mail: license@commerce.state.ak.us

MED

For Office Use Only
RECEIVED
JUNEAU
APR 13 2009

Division of Corporations, Business
and Professional Licensing

BOARD ACTION DATA BANK INQUIRY

Instructions to the Applicant:

Type or print legibly. Complete Part I below. Mail this form to the Federation at the address below.

PART I

Full Name (Last, First, Middle) Kaminski, Anna W	Maiden or Other Names Used: none	Date of Birth (MM/DD/YYYY) 05/22/1959
Mailing Address (Street) 523 N. 48th St.	Place of Birth NYC, New York U.S.	
City/State/Zip Seattle, WA 98103	II International Grad., ECFMG No.	
Medical/Osteopathic School (Name and Location) UCB/UCSF Joint Medical Program San Francisco	Year of Graduation 1990	

YOU MUST MAIL THIS FORM TO:

Federation of State Medical Boards of the United States, Inc.
Post Office Box 619850
Dallas TX 75261-9850

FOLLOWING TO BE COMPLETED BY FSMB DATA BANK STAFF ONLY

PART II

Instructions to the Data Bank Staff:

Please search the data bank for any record of this practitioner. Please forward your report to the medical board at the letterhead address.

FOR FEDERATION USE ONLY
WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN
APR 06 2009
Barbara S. Schneidman, MD Barbara S. Schneidman, MD, MPH Interim President And Chief Executive Officer

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

BOARD ACTION SEARCH RECONCILIATION REPORT

April 6, 2009

Alaska State Medical Board
Attn: Leslie A. Gallant, Exec. Admin.
550 West Seventh Ave Ste. 1500
Anchorage, AK 99501

Re: Board Action Query Dated: April 6, 2009

Your Reference Number:

FSMB Batch Number: BQ1602712

PRACTITIONERS CLEARED WITH NO ACTION AS OF APPLICABLE SEARCH DATE

Name	DOB	School	Yr/Grad	Request ID
[REDACTED]				
Kaminski, Anna W	05/22/1959	005050	1990	20697651
[REDACTED]				

Please refer to prior clearance reports to determine the search date for each practitioner.



ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Avenue - Ninth Floor)
Post Office Box 110806 Juneau AK 99811-0806
A - K: 907/465-2756 L - Z: 907/465-2541
E-mail: license@commerce.state.ak.us

MED

For Office Use Only

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APR 07 2009

Division of Corporations, Business
and Professional Licensing

VERIFICATION OF STATUS OF DEA REGISTRATION

Instructions to the Applicant: Type or print legibly. Complete Part I below and mail this form to the DEA.

PART I

Full Name (Last, First, Middle) Kaminski Anna W	Maiden or Other Names Used: W	Date of Birth (MM/DD/YYYY) 05/22/1979
Mailing Address 2001 E. Madison	City Seattle	State WA Zip 98122-2959
Address Where DEA Registered 4500 9th Avenue NE Suite 324 Seattle WA 98105		DEA Registration No. BK5882457
Signature of Applicant <i>Anna W Kaminski</i>		Date of Signature 3/9/09

YOU MUST MAIL THIS REQUEST FORM TO:

Drug Enforcement Administration
Attn: Diversion Unit
400 Second Avenue West
Seattle, WA 98119-4013

FOLLOWING TO BE COMPLETED BY DEA STAFF ONLY

PART II

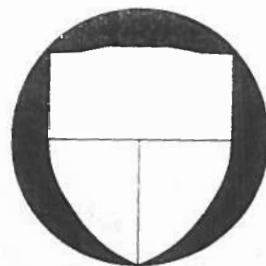
Instructions to the DEA staff: Please search your records and advise if there is any derogatory information on file against this physician. Please return this form directly to the State Medical Board at the letterhead address.

Comments: _____

For DEA Use Only

The files of this office contain
no derogatory information
relative to the above subject.
D.E.A.

American Board of Family Medicine



Anna Wildy Kaminski, M.D.

is a Diplomate of this Board and
having met its continuing requirements is hereby

Recertified

as a

Diplomate

2007-2014


Chair

05/26/2017




President

0049



ALASKA STATE MEDICAL BOARD

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Division of Corporations, Business
and Professional Licensing

Receipt No.

3552345

Amount

no money

3.9.09 840.75
Nonrefundable Application Fee \$250
Permanent License Fee \$590
Total Due \$840

APPLICATION FOR LICENSE TO PRACTICE MEDICINE OR OSTEOPATHY

PART I PERSONAL IDENTIFICATION INFORMATION

(Type or Print Legibly)

1	Full Legal Name (Last, First, Middle)	Last Kaminski	First Anna	Middle W.
2	Other Names Used (Incl. Maiden Name)			
3	Legal Name Changes (Provide copy of documents)			
4	Date of Birth	Mo Day Year 05/22/1959	Place of Birth (City, State/Country): New York, NY U.S.A.	Sex: <input type="checkbox"/> M <input checked="" type="checkbox"/> F
5	Full Practice Address	Mailing Address (Include street address if using post office box) Planned Parenthood, 2001 East Madison / 3231 Glacier Hwy City Seattle / Juneau State WA / AK Zip Code 98122 / 99801		
6	Full Residence Address	Mailing Address (Include street address if using post office box) → 523 N 48th St City Seattle State WA Zip Code 98122 Duration at this address: Yrs: 18 Mos: 5		
7	Telephones	Area Code/Phone Work:	Area Code/Phone Home:	
8	Preferred Address of Record (See Address of Record Information.)	<input checked="" type="checkbox"/> Use Practice Address Send my mail to this address.	<input type="checkbox"/> Use Residence Address Send my mail to this address.	
9	E-Mail Address	Do you wish to be included on an email notification list? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Anna.Kaminski@ppgnw.org		
10	Professional Designation	Application Based on: <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input checked="" type="checkbox"/> Credentials (Licensed in other state) <input type="checkbox"/> Examination (Not licensed in other state)		
11	Previous License or Permit in ALASKA?	<input checked="" type="checkbox"/> NO <input type="checkbox"/> YES → If YES, when and what type: Year: _____ <input type="checkbox"/> Resident <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Permanent License		

APPLICANT: As required by state law, please print
CONFIDENTIAL information and last

Applicant's Social Security Number

Number in the space below. It is considered

12. Military Service

Have you ever been in the armed forces?

☐ Yes

☒ No

If YES, branch of service: _____ Date of commission: _____

Date and Type of Discharge: _____

Locations where you served: _____

PART II EDUCATION

13. Medical School Education

List the medical school(s) you attended and from which you graduated. If you attended more than one medical school, provide your reason for changing medical schools on a separate sheet of paper signed and dated by you.

Completed

Yr	SCHOOL	MAILING ADDRESS	(MM/YYYY)	Yes/No
1	UCSF-UCB Joint Medical Program	400 Parnassus Ave San Francisco, CA	From 05/1985 To 06/1990	YES
2			From To	
3			From To	
4			From To	

13 a. If your medical school is an international one, is it listed on the Medical Board of California's List of Approved Schools? ☐ Yes ☐ No - If you check 'no', please call our office immediately.

14. Postgraduate Training

List internship, residency, or fellowship training programs chronologically.

Completed

Yr	HOSPITAL	MAILING ADDRESS	(MM/YYYY)	Yes/No
1	Group Health Cooperative of Puget Sound	200 15th Ave E Seattle, WA 98122	From 1990 To 1993	Yes
2	Cedar River Clinic	Seattle, WA	From To 1993	yes
3	Aurora Medical Services	1001 Broadway Suite 320 Seattle, WA 98122	From To 1992	yes
4			From To	
5			From To	
6			From To	

Applicant Name: Anna Kaminski

Date: 4/5/2009

15. **Examination History** Please specify National Boards, FLEX, LMCC, USMLE, or a state written examination.

Exam Series	Location	Date Taken (MM-YYYY)	Result	
National Board	UCSF	05-1987	Pass	Fail
NBME	UCSF	5-1990	Pass	Fail
NBME	UW	7-1991	Pass	Fail

16. **ECFMG Certification - International Graduates Only** Attach a certified true copy of your certificate to this application.

If you are an international medical graduate, have you taken the ECFMG exam? ☐ Yes ☐ No

If Yes, ECFMG Certificate No.

Date Issued (MM/YYYY)

17. **Self-Designated Specialty**

If you are board certified, attach a certified true copy of board certificate.

Specialty/Subspecialty	Board Certified? Yes/No/Year	What Board?	Recert. Date -Year
Family Practice	2007	ABFP	2017

PART III PROFESSIONAL ACTIVITIES

18. **Professional Licensure**

Please list all states or territories of the United States, provinces of Canada, or other countries in which you hold or have ever held medical licenses. Include instructional or training permits. **Failure to disclose all licenses may result in disciplinary sanctions or denial.**

	Location (State, territory, etc.)	License Number	Date Issued	Current Status
1	Washington	MD00030198	09/15/1992	Active (05/22/2009)
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

Applicant Name: Anna Kaminski

Date: 11/5/09

19. Other Professional Licensure

Other than as a physician, have you ever been licensed in any jurisdiction in any other profession of the healing arts?

☒ No

☐ Yes

If Yes, please complete the following:

Profession (DDS, DC, RN, PA-C, DC, etc.)	Jurisdiction (State, territory, country, etc.)	Date Licensed	Was License Disciplined?
			<input type="checkbox"/> No <input type="checkbox"/> Yes
			<input type="checkbox"/> No <input type="checkbox"/> Yes

If you have responded 'yes' to question 19, verifications of good standing for each license must be submitted for all other health care professions under which you have been licensed by those jurisdictions.

20. Medical Societies and Professional Organizations

Name of Organization	Address	Date From/To - YYYY
Association of Reproductive Health Professionals	1330 Broadway, Oakland, CA 94612	10/2006 - current
Physicians for Reproductive Choice and Health	55 W 34th St NYC NY 10018	2007 - current
Medical Students for choice	PO Box 40188 Philadelphia, PA 19106	2005 - 2007
American Association of University Women		2000 - 2005

21. Hospital Affiliations

Have you ever held hospital privileges?

☒ Yes

☐ No

If Yes, please list all hospitals in which you have been credentialed within the immediate past five years.

HOSPITAL	MAILING ADDRESS	WHEN PRIVILEGED (MM/YYYY)
1 Virginia Mason Clinic	1100 9th Ave Seattle, WA 98101	From 10/1994 To 2/2002
2 Swedish Medical Center	747 Broadway Seattle, WA 98122-4307	From 8/1995 To
3 Group Health	200 15 Ave E	From 6/1993 To 10/1994
4		From
5		
6		
7		

See Corrected Copy.

If necessary, continue to list of a separate sheet of paper labeled

Applicant Name: Anna Kaminski

09

19. Other Professional Licensure

Other than as a physician, have you ever been licensed in any jurisdiction in any other profession of the healing arts?

☒ No

☐ Yes

If Yes, please complete the following:

Profession (DDS, DC, RN, PA-C, DC, etc.)	Jurisdiction (State, territory, country, etc.)	Date Licensed	Was License Disciplined?
			<input type="checkbox"/> No <input type="checkbox"/> Yes
			<input type="checkbox"/> No <input type="checkbox"/> Yes

If you have responded 'yes' to question 19, verifications of good standing for each license must be submitted for all other health care professions under which you have been licensed by those jurisdictions.

20. Medical Societies and Professional Organizations

Name of Organization	Address	Date From/To - YYYY
ARHP	All prior application	
PRCH		
MS4C.		

21. Hospital Affiliations

Have you ever held hospital privileges?

☒ Yes

☐ No

If Yes, please list all hospitals in which you have been credentialed within the immediate past five years.

HOSPITAL	MAILING ADDRESS	WHEN PRIVILEGED (MM/YYYY)
1	0 in past 5 years	From
		To
2		From
		To
3		From
		To
4		From
		To
5		From
		To
6		From
		To
7		From
		To

If necessary, continue to list of a separate sheet of paper labeled with your name and signed by you.

Applicant Name: Anna Kaminski MD Date: 7/22/09

In answer to a "yes" response on question 23 of the Alaska State Medical Board Application for Anna W. Kaminski.

Medical Malpractice History

Date of Incident: 08/1994

Teen with twin pregnancy with a subsequent preterm delivery. ~~was~~ seen by me once for triage. One twin was stillborn, one twin was disabled.

Date suit or claim was filed: 11/27/1996

Status in the legal action:

Co-defendant

Current status of suit:

Judgement for the defense

Date of judgement/dismissal:

3/23/1998, found for the defense

Anna W. Kaminski 3/27/09



ALASKA STATE MEDICAL BOARD

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APR 01 2009**

Division of Corporations, Business
and Professional Licensing

AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, Anna W. Kaminski, residing at
(Please print full name)
523 N. 48th St, Seattle, WA 98103, hereby authorize the Alaska
(Please print full address)


Division of Corporations, Business, and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the Division to discuss my records with persons or organizations that are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.


Signature of Applicant

3/9/09
Date

206-632-6276
Home Phone Number

206-799-1268
Work Phone Number

22. Medical Work History

Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school to the present date with no more than a 60-day gap in time. You may attach a detailed curriculum vitae as long as all information is included. Please explain any gap in time from practice of more than sixty (60) days' duration.

	Date (MM/YYYY)	Location (City, State, or Other Country)	Activity
Fr	6/1993	Seattle, WA	Locums, Group Health
To	10/1994	Burien, WA	4 days/wk. Primary Care + OB
Fr	9/1992	Yakima, WA	Locums, Cedar River Health
To	4/1995	Renton, WA	2 days/month,
Fr	6/1993	Seattle, WA	Aurora Medical Services
To	7/2001		call and < 2 days/month
Fr	10/1994	Seattle, WA	Highpoint Medical Clinic
To	10/2002		4 days/wk, primary care + OB
Fr	8/1995	Seattle, WA	Planned Parenthood, Western Washington
To	1/2003		locums 2-6 days/month
Fr	1/2003	Seattle, WA	Planned Parenthood
To	current		4 days/week
Fr	6/1990	Seattle, WA	Residency, Group Health
To	6/1993		F.P
Fr			
To			
Fr			
To			
Fr			
To			

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

Applicant Name:	Anna Kaminski MD	Date:	12/11/08
-----------------	------------------	-------	----------

23. Medical Malpractice History

Have you ever had any claims of malpractice filed against you?

☐

No

☒

Yes

If Yes, please list all claims of malpractice filed against you below. Include all settlements, judgments, awards, and claims for which no money was paid. For each case listed below, provide a brief description on a separate sheet of paper labeled with your name and signed by you. Include the nature of the case, the allegations, and your response to the allegations. Please do not send letters from attorneys or insurance carriers.

Case No.	Date of Case (Mo/Yr)	Jurisdiction (State, etc.)	Nature of Allegation	Amount of Settlement Paid on Your Behalf
1	3/96	WA	Malpractice in care of twin pregnancy	0
2				
3				
4				
5				
6				

SPECIAL INSTRUCTIONS FOR PARTS IV AND V

In responding to the questions in Parts IV and V below, please check the appropriate box next to each question. A "Yes" response to a question does not automatically result in a denial of license application. For each "Yes" response to any question, you must provide a separate, signed statement giving full details including dates, locations, type of action, organizations or parties involved, and specific circumstances. When in doubt about your response, disclose and provide the explanation requested. Please answer parts A and B of each question.

CONFIDENTIALITY

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

PART IV DISCIPLINARY HISTORY

IMPORTANT! PLEASE READ

BEFORE ANSWERING THE DISCIPLINARY HISTORY QUESTIONS 24 through 37.

For the purpose of this application, the word "**discipline**" is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Academic Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. Please include non-reported disciplinary actions.

The word "**investigation**" is used in questions below. For the purpose of this application, the word investigation means to carry out an examination or inquiry in order to ascertain facts regarding a complaint, an event or a person. Other boards may use other words including but not limited to: inquiry, complaint, examination, exploration, inspection, consideration, review, probe, or scrutinize. Investigations are usually, but not always, precipitated by a complaint filed by a person or organization against a license holder with an agency, usually with some official standing. If you are unsure about your response to a question, please contact our office or... **WHEN IN DOUBT, DISCLOSE AND EXPLAIN.**

- 24a. ☒ No ☐ Yes Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?
- 24b. ☒ No ☐ Yes Is any such action pending?

Applicant Name: Anna Kaminski	Date: 2/5/09
-------------------------------	--------------

Part IV

Disciplinary History Questions Continued

- 25a. ☒ No ☐ Yes Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal?
- 25b. ☒ No ☐ Yes Is any such action pending?
- 26a. ☒ No ☐ Yes Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction?
- 26b. ☒ No ☐ Yes Is any such action pending?
- 27a. ☒ No ☐ Yes Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction?
- 27b. ☒ No ☐ Yes Is any such action pending?
- 28a. ☒ No ☐ Yes Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges (except for late medical records)?
- 28b. ☒ No ☐ Yes Is any such action pending?
- 29a. ☒ No ☐ Yes Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction, or termination?
- 29b. ☒ No ☐ Yes Is any such action pending?
- 30a. ☒ No ☐ Yes Have you ever been disciplined by a medical school or post-graduate training program? See Important information block on discipline on page 6.
- 30b. ☒ No ☐ Yes Is any such action pending?
- 31a. ☒ No ☐ Yes Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)?
- 31b. ☒ No ☐ Yes Is any such action pending?
- 32a. ☒ No ☐ Yes Have you ever been under investigation by any medical licensing jurisdiction or authority?
(If you are unsure about your response to this question, please refer to the instructions and definitions for this section on page six of this application above. When in doubt, disclose.)
- 32b. ☒ No ☐ Yes Is any such action pending?
- 33a. ☒ No ☐ Yes Have you ever had a medical license application denied by any medical licensing jurisdiction or authority?
- 33b. ☒ No ☐ Yes Is any such action pending?

Applicant Name:

Anna Kaminski

Date:

2/5/09

Part IV Disciplinary History Questions Continued

- 34a. ☒ No ☐ Yes Have you ever voluntarily or involuntarily withdrawn an application for a license to practice medicine in any United States jurisdiction or any international jurisdiction?
- 34b. ☒ No ☐ Yes Is any such action pending?
- 35a. ☒ No ☐ Yes Have you ever voluntarily or involuntarily surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction?
- 35b. ☒ No ☐ Yes Is any such action pending?
- 36a. ☒ No ☐ Yes Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine?
- 36b. ☒ No ☐ Yes Is any such action pending?
- 37a. ☒ No ☐ Yes Has your employment by a clinic, hospital, or other health care organization ever been terminated involuntarily or voluntarily as a result of an actual or potential investigation or as grounds for disciplinary proceedings?
- 37b. ☒ No ☐ Yes Is any such action pending?

PART V PERSONAL HISTORY

Please refer to Special Instructions on page 6 before answering these questions. For the purposes of the questions in this section, the following words or phrases are defined:

"Ability to Practice Medicine"

Includes, but is not limited to, the cognitive capacity to make appropriate clinical diagnoses and exercise reasonable medical judgments and to learn and keep abreast of medical developments; the ability to communicate those judgments and medical information to patients and other health care providers with or without the use of aids or devices, such as voice amplifiers; and the physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"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.

"Chemical Substance(s)"

Any natural or synthetic chemical substance, alcohol, drugs, or medications, including those chemical substances taken pursuant to a valid prescription for legitimate medical purpose and in accordance with the direction(s) of the prescribing physician, as well as those used illegally.

"Controlled Substances"

Means any substance as defined in either Alaska Statute 11.71.900 or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513) and any subsequent amendment(s).

"Currently"

Does not mean on the day of, or even in the weeks or months preceding the completion of this application; rather, "currently" means recently enough so that the event, condition, behavior, impairment, limitation, etc., may have an ongoing impact on the applicant's ability to practice medicine in a competent manner.

"Illegal Drug Use"

Means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed physician who prescribed the controlled substance or dangerous drug.

Applicant Name: Anna Kaminski

Date: 2/5/09

Part V Personal History Questions Continued

38. ☒ No ☐ Yes Has your ability to practice medicine in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?
39. ☒ No ☐ Yes Are you currently experiencing any medical condition or disorder that impairs your judgment or that otherwise affects your ability to practice medicine in a safe and competent manner?
40. ☒ No ☐ Yes Since completing your postgraduate training, have you ever been physically or mentally unable to practice medicine for a period of sixty (60) days or more?
41. ☒ No ☐ Yes Are you currently the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner?
42. ☒ No ☐ Yes Have you ever been diagnosed with, been treated for, or do you currently have voyeurism, pedophilia, exhibitionism, or any other sexual behavior disorder?
(Please note that "sexual behavior disorder" does not include sexual preference.)
43. ☒ No ☐ Yes Are you currently engaged in the illegal use of any drug, whether by ingestion, injection, inhalation, or any other method?
44. ☒ No ☐ Yes Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?
45. ☒ No ☐ Yes Have you ever been voluntarily or involuntarily committed or confined to any facility for mental health care?
46. ☒ No ☐ Yes Have you ever been diagnosed with, treated for, or do you currently have (check the appropriate condition):
- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Depressive Neurosis | <input type="checkbox"/> Kleptomania |
| <input type="checkbox"/> Hypomania | <input type="checkbox"/> Any Dissociative Disorder | <input type="checkbox"/> Pyromania |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Any Psychotic Disorder | <input type="checkbox"/> Delirium |
| <input type="checkbox"/> Major Depression | <input type="checkbox"/> Any Organic Mental Disorder | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Seasonal Affective Disorder | | |
47. ☒ No ☐ Yes Have you ever taken, or are you currently taking, any controlled substance for any of the disorders listed in question 46 above?
If you responded 'Yes' to question 46, on a separate sheet of paper signed and dated by you, please list all medications you are taking, the dosage, frequency, and who is prescribing the medications for you.
48. ☒ No ☐ Yes Have you ever been adjudicated or declared incompetent or been the subject of an incompetency proceeding?

Applicant Name:

Anna Kaminski

Date:

2/5/09

PART VI SWORN STATEMENT

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content thereof.

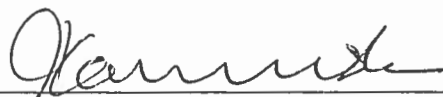
I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct.

I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy as prescribed by this application, and that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof.

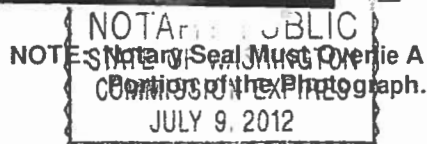
I further certify that the photograph that appears below is a true likeness of myself taken within the past 60 days.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification or misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice medicine in the state of Alaska.

I carefully read all the instructions in the application including the instructions under Part IV, Disciplinary History, on page 6. ☒ Yes

Applicant Signature 


Date 2/26/09.



SUBSCRIBED AND SWORN TO before me, a Notary

Public, in and for the State of AK

this 26 day of Feb, _____

Notary Signature 

My commission expires: July-9-2012

WARNING: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application is subject to imprisonment for not more than one year, a fine of not more than \$5,000, or both.



ALASKA STATE MEDICAL BOARD

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MAR 02 2009

Division of Corporations, Business
and Professional Licensing

AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, Anna W. Kaminski, residing at
(Please print full name)
523 N. 48th St, Seattle, WA 98103, hereby authorize the Alaska

(Please print full address)

Division of Corporations, Business, and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the Division to discuss my records with persons or organizations that are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Signature of Applicant

Date

12/11/08 2/26/09

206-632-6276

Home Phone Number

206-799-1268

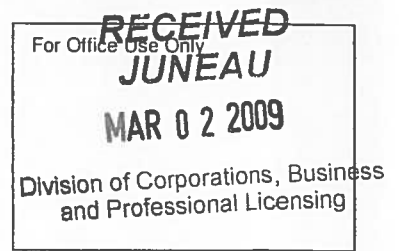
Work Phone Number



ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development
Division of Corporations, Business, and Professional Licensing
(333 Willoughby Avenue - Ninth Floor)
Post Office Box 110806 Juneau AK 99811-0806
A - K: 907/465-2756 L - Z: 907/465-2541
E-mail: license@commerce.state.ak.us

MED



LIST OF HOSPITALS WHERE PRIVILEGED

Instructions to the Applicant:

Type or print legibly. List below all hospitals where you currently hold or have held privileges in the last five years. If you have not held privileges within the past five years or never held privileges, please write "None" on this form, sign it, and submit this form as part of your application. Please include residency privileges if appropriate.

HOSPITAL	MAILING ADDRESS	WHEN PRIVILEGED (MM/YYYY)	
		From	To
1 Virginia Mason Clinic	1100 9th Ave	10/1994	
	Seattle, WA 98101	To	2/2002
2 Swedish Medical Center	747 Broadway	From	8/1995
	Seattle, WA 98122-4307	To	
3		From	
		To	
4	No Hosp. privileges past 5 years	From	
		To	
5		From	
		To	
6		From	
		To	
7		From	
		To	
8		From	
		To	

I certify that listed above are all hospitals where I hold or have held privileges in the past five years. I understand it is my responsibility to request these hospitals submit a letter to the board to complete my application for licensure. I certify under penalty of unsworn falsification that the above information is true and correct.

Signature

[Signature]

Date

04/15/09

Warning: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application has committed a Class A misdemeanor.

ALASKA STATE MEDICAL BOARD

APPLICANT INFORMATION

Applicant

Last Name: KAMINSKI

First Anna

Middle: Wildy

Prof. Desg MD

Medical

(MD/DO/DPM)

School: UCSF-UCB Jt Medical Program

Year Graduated 1990

ABMS Bd yes

Specialty: Family Medicine

Subspe.

Subspe.

Application based on: Credentials (state)

WA

Examination:

Start Date:

(if known)

\$250 Application Fee

Receipt No 3552345

Date Pd: 03/02/09

\$590 License Fee

Receipt No 3552345

Date Pd: 03/02/09

Receipt No

Date Pd:

APPLICATION DOCUMENTS

03/02/09 Application, 10-pgs, Photo/Notary

03/02/09 Auth. for Release of Records

04/20/09 Exam Scores (Indicate type: USMLE, FLEX, NBME, State, or Combination)

NBME

05/11/09 Medical School Diploma

Transcript:

n/a International Medical School

Translation:

CA Approved List?

06/15/09 Verification from Med School

05/11/09 Postgraduate Certificates

Accredited: xxx

US Grad Before 1995

xx

(1-Year Required)

US Grad After 1995

(2-Yrs Required)

n/a International Graduate - Licensure based on one of the following criteria:

ECFMG No.

3-Yrs of Accredited Postgraduate Training

Year-for-Year Substitution as Faculty

ABMS Board Certification, Current

Current, Active License in Other State for 3 Yrs

Board:

State:

Number of Years Claimed - Max. 3

04/13/09 Verifications - PG Prgrms

PGY1 04/13/09

PGY2 04/13/09

PGY3 04/13/09

07/27/09 Verifications of Licensure:

State WA

Rec'd 05/07/09

State

Rec'd

State

Rec'd

State WA

Rec'd 07/27/09

State

Rec'd

State

Rec'd

State

Rec'd

State

Rec'd

State

Rec'd

Jurisdictions not listed on application:

WA 1980-1992

Discovered on: AMA profile

03/02/09 Hospital Privileges List

None Hospital Privileges Verifications Complete (see app list)

7/22 sending statement no privileges at Swedish/VA Mason past 5yrs

Rec'd new pg 4 7/23/09 no hospital privileges within 5 yrs

04/07/09 DEA Clearance Report

04/13/09 FSMB Board Action Data Bank Report

04/02/09 AMA/AQA Physician Profile

07/27/09 NPDB Report - Requested

Rec'd

WA 1990-1992 on profile not on app

Yes Irregularities:

#23 malpractice

Yes / No Examiners Notes:

Anna.Kaminski@ppgnw.org

07/30/09 App Status Letters Sent - Date(s):

04/27/09 6/16/09em 7/22ph+em

Yes / No State Documents:

07/30/09 File Sent to Anchorage for Review

Prepared by Licensing Examiner Sherwood

Approved - Issue Permit

Decision Declined - Refer to Board

Interview Required - See Notes

Comments:

Signed

Date

Temporary Permit No.

Issued

Board Review Date

06-4990 (Rev 07/2006)

ALASKA STATE MEDICAL BOARD
APPLICANT INFORMATION

CHECKLIST - TEMPORARY PERMIT

Revised: 07/28/09

By: LS

Applicant

Last Name: KAMINSKI

First Anna

Middle: Wildy

Prof. Desg MD

(MD/DO/DPM)

Medical

School: UCSF-UCB Jt Medical Program

Year Graduated 1990 ABMS Bd yes

Specialty: Family Medicine

Subspe. _____

Subspe. _____

Application based on: Credentials (state) WA

Examination: _____

Start Date: _____ (if known)

\$250 Application Fee

Receipt No 3552345

Date Pd: 03/02/09

\$590 License Fee

Receipt No 3552345

Date Pd: 03/02/09

Receipt No. _____

Date Pd: _____

APPLICATION DOCUMENTS

Date Rec'd Document

Processing Notes

03/02/09 Application, 10-pgs, Photo/Notary

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05/11/09 Medical School Diploma

Transcript: _____

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Current, Active License in Other State for 3 Yrs

Board: _____

State: _____

Number of Years Claimed - Max. 3

04/13/09 Verifications - PG Prgms

PGY1 04/13/09

PGY2 04/13/09

PGY3 04/13/09

07/27/09 Verifications of Licensure:

State WA

Rec'd 05/07/09

State _____

Rec'd _____

State _____

Rec'd _____

State WA

Rec'd 07/27/09

State _____

Rec'd _____

State _____

Rec'd _____

State _____

Rec'd _____

State _____

Rec'd _____

State _____

Rec'd _____

Jurisdictions not listed on application:

WA 1990-1992

Discovered on: AMA profile

03/02/09 Hospital Privileges List

None Hospital Privileges Verifications Complete (see app list)

04/07/09 DEA Clearance Report

04/13/09 FSMB Board Action Data Bank Report

04/02/09 AMA/AOA Physician Profile

07/27/09 NPDB Report - Reqstd

Recd _____

07/27/09 Yes Irregularities:

#23 malpractice

Yes / No Examiners Notes:

Anna.Kaminski@ppgnw.org

07/30/09 App Status Letters Sent - Date(s):

04/27/09 6/16/09em 7/22ph+em

Yes / No State Documents:

07/30/09 File Sent to Anchorage for Review

Prepared by Licensing Examiner Sherwood

Board Member/Designee Review for Issuance of Temporary Permit

Approved - Issue Permit

Decision Declined - Refer to Board

Interview Required - See Notes

Comments:

Signed

Date

Temporary Permit No. _____

Issued _____

Board Review Date _____

ANNA KAMINSKI
REDACTION LOG

Bates No(s).	Date(s)	Brief description of record	Information withheld	Authority to withhold information
0027	07/31/2009	NPDB Query	All	45 CFR § 60.20; AS 40.25.120(a)(4).
0037-0044	03/27/2009	AMA Physician Profile	All	AS 40.25.120(a)(4). <i>See also</i> 42 U.S.C. § 11137(b).
0047	04/06/2009	FSMB Report	Information that might identify a third party	Art. 1, § 22, Alaska Const.; AS 40.25.120(a)(6)(C); AS 40.25.120(a)(4).
0050	02/05/2009	License application	Social Security number	Art. 1, § 22, Alaska Const.; AS 45.48.400; AS 40.25.120(a)(4).