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

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

MEDICAL UNIT
SEP 21 1992
RECEIVED

Anna Wildy Kaminski, M.D.

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

Attest Edward J. Stemmler, MD
Chairman of the Board

SEAL Robert L. Volle, PhD
President of the Board

Philadelphia, Pa
07/01/91

Certificate # 371761

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from U Calif San Francisco School of Medicine in JUNE 1990 and whose birth date is 05/22/1959. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/87		
Anatomy	550	84
Physiology	435	76
Biochemistry	455	78
Pathology	460	78
Microbiology	350	71
Pharmacology	415	75
Behavioral Sciences	405	75
TOTAL TEST(Minimum Passing Score 380/75)	430	76
PART II passed 04/90		
Medicine	440	79
Surgery	520	82
Obstetrics and Gynecology	500	82
Public Health and Preventive Medicine	525	83
Pediatrics	480	81
Psychiatry	370	76
TOTAL TEST(Minimum Passing Score 290/75)	465	80
PART III passed 03/91		
A General Test of Clinical Competence		
TOTAL TEST(Minimum Passing Score 290/75)	505	82

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

SEE OTHER SIDE FOR SCORE INFORMATION

Melanie Valente
Secretary for Certification

SEAL

09/14/92
Date

WA0239

INTERPRETATION OF SCORES

STANDARD SCORES

Part I and Part II Examinations Passed Prior to June 1991

Total test score **and** subject scores are reported. The total test score is based on the number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Part I Examination - June & September 1991 Part II Examination - September 1991 & April 1992

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All Part III Examinations

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

SCALE SCORES

For all examinations, the scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

Washington State Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

FOR [illegible]DATION ONLY

MEDICAL UNIT

JUL 15 1992

RECEIVED

MAKE REMITTANCE PAYABLE TO STATE TREASURER

APPLICATION FOR LICENSE TO PRACTICE MEDICINE

APPLICABLE FOR M.D.'s ONLY

FOR OFFICE USE ONLY

CERTIFICATE NO. 30198 ISSUE DATE 9-1592 EXPIRATION DATE _____

Application for licensure is made by: (check one)

- ☒ National board waiver
- ☐ Endorsement of state examination
- ☐ FLEX examination waiver
- ☐ LMCC (must have been obtained after 1969)
- ☐ FLEX examination

State _____ Date of examination requested (month and year) _____

PLEASE TYPE OR PRINT CLEARLY

Applicant's Name KAMINSKI (LAST) ANNA (FIRST) W (MIDDLE INITIAL)

Mailing Address 523 N. 48th St.

City SEATTLE State WA ZIP 98103 County KING

Telephone No. 206 632-3585 (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.) Social Security Number _____ (REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND NOT REQUIRED FOR LICENSING APPROVAL.)

Home Address SAME (STREET) (CITY) (STATE) (ZIP)

Congressional District _____

Sex (F or M) F Birthdate 5 (MONTH) 22 (DAY) 59 (YEAR)

Birthplace NYC (CITY) NY (STATE) NY (COUNTY)

Medical specialty FAMILY PRACTICE

Medical school UNIVERSTY CALIFORNIA, SAN FRANCISCO (NAME/COUNTY) Year of Graduation 1990

Have you previously applied for a Washington state medical license or limited license? ☒ Yes ☐ No

List other name(s) that appear on documents or credentials _____

Follow carefully all instructions in general instructions - all applicants. It is the responsibility of the applicant to submit or request to have submitted, all required supporting documents.

IDENTIFICATION

HEIGHT	WEIGHT
5' 4"	125
COLOR OF EYES	COLOR OF HAIR
BR	BR

Att... 5-23-92

N

1. Orig
2. No L
3. Taken Within One Year of Application
4. Close Up Front View of Self - Not Profile
5. Instant Polaroid Photographs Not Acceptable

PERSONAL DATA

	Yes	No
1. Have you ever had a license to practice medicine suspended, revoked, restricted or denied in any state, federal or foreign jurisdiction?	☐	☒
2. Have you ever had hospital privileges, or medical society membership revoked, suspended or restricted on grounds of unprofessional conduct, incompetence, negligence, or unsafe practices?	☐	☒
3. Have you ever been convicted of any gross misdemeanor or felony relating to the practice of medicine?	☐	☒
4. Have you ever been the recipient of any disciplinary action, including reprimand or have you ever entered a stipulated agreement or agreed to discontinue an act alleged as a violation of law or an unsafe practice?	☐	☒
5. Has any information pertaining to you been submitted to the National Data Bank?	☐	☒

If response to 1, 2, 3, or 4 is affirmative, attach certified copies of orders, stipulations, agreements,. charges, judgements sentence, findings and nature of decisions. If on parole or probation, include a letter from the supervising officer indicating progress.

6. Have you ever been found guilty of the violation of any drug law, or prescribing controlled substances for yourself?	☐	☒
7. Have you ever been involved in the possession, use, prescription for use, or diversion of controlled substances or legend drugs in any other than for legitimate or therapeutic purposes?	☐	☒
8. Have you ever voluntarily submitted or been required to submit for treatment for alcohol dependency?	☐	☒

If response to 5, 6 or 7 is affirmative, attach certified copies of charges, sentence, order, stipulation and/or disposition. Also include letters from the treating professional and/or institution stating details of condition or addiction, treatment and prognosis.

9. Have you ever received treatment for a mental illness?	☐	☒
10. Have you ever been released from or restricted in a medical program becasuse of a mental condition or illness?	☐	☒

If response to 8 or 9 is affirmative, attach certified copies of diagnosis, treatment, or prognosis along with letters from any treating physician and/or professional stating details of condition and prognosis.

11. Have you ever voluntarily given up privileges, a license to practive, or agreed to restrict your practice in lieu of or to avoid formal action? (if yes, provide a notarized statement of explanation)	☐	☒
12. Have you been named in any malpractice suits alleging your incompetence or negligence in the practice of medicine? If yes, include the nature of the case, date, and summarize care given. Enclose a copy of the original complaint and settlement or final disposition. If pending, indicate the status.	☐	☒

Failure To Give Complete And True Information Constitutes Cause For Denial Of Your Application For Licensure

EDUCATION AND EXPERIENCE

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (Attach additional 8 1/2 x 11 sheet if necessary)

SCHOOLS ATTENDED-LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.	NUMBER OF YEARS ATTENDED	ATTENDANCE		DIPLOMA OR DEGREE OBTAINED QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH
		ENTRANCE DATE MO./YR.	LEAVING DATE MO./YR.	
Medical Education (List all Medical Schools Attended)		6/85	6/90	M.D. and M.S. in Health and Medical Sciences
UCSF - UCB Joint Medical Program				
Post-Graduate Training (List all programs attended)				
GROUP HEALTH	# 2	6/90	7/92	—

In Chronological Order List All Professional Experience Received Since Graduation From Medical School To The Present.
(Exclude Activities Listed Under Other Sections.) (Identify Any Periods Of Time Break Of 30 Days or More.) (Attach additional 8 1/2 x 11 sheet if necessary)

INDICATE NATURE OF EXPERIENCE OR PRACTICE	INCLUSIVE DATES OF EXPERIENCE	
	BEGINNING MO./YR.	ENDING MO./YR.
FAMILY PRACTICE RESIDENCY GROUP HEALTH COOPERATIVE	6/90	7/92

FIFTH PATHWAY (Foreign Trained Applicants Only)

(Attach additional 8 1/2 x 11 sheet if necessary)

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

Please List Hospitals Where Privileges Have Been Granted Within The Past Five (5) Years. (Attach additional 8 1/2 x 11 sheet if necessary)

(FOR LOCUM TENENS, ENTER ONLY THOSE OF A 30 DAY OR LONGER DURATION. SEE INSTRUCTIONS REGARDING REPORTS AND VERIFICATION.)	BEGINNING DATE	ENDING DATE

NOTE: IF ADDITIONAL 8 1/2 X 11 SHEET(S) ATTACHED, PLEASE LABEL AS TO SUBJECT, i.e., FIFTH PATHWAY

LICENSES IN OTHER STATES/COUNTRIES

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

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

AIDS AFFIDAVIT

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS. I understand I must maintain records documenting said education, for two (2) years and be prepared to submit those records to the Department if requested. (WAC 308-52-620)

Anna W Kaminski
SIGNATURE

6/19/92
DATE

APPLICANT'S ATTESTATION

I, ANNA W. KAMINSKI, state that I am the person described and identified in this
(PRINT OR TYPE FULL NAME OF APPLICANT)

application, that I have read 18.130.170 RCW and 18.130.180 RCW of the Uniform Disciplinary Act, and that I have answered all questions in this application truthfully and completely and the documentation provided in support of the application is, to the best of my knowledge, accurate. I understand that the Department may require additional information from me prior to making a determination regarding my application.

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

Anna W Kaminski
SIGNATURE OF APPLICANT

6/19/92
DATE

PHYSICIAN LICENSURE WORKSHEET

NAME: KAMINSKI, ANNA		DOB: 5-22-59	
7-15-92 Application Received			Application Complete
X Fee Received	X Photo	X Affidavit	X AIDS
1	Personal Data Section Complete		Missing
	Yes Response to #____,____,____		Documentation Received
7	Chronology Complete		Missing Chronology to - to
7/92 MDB	7-92 AMA		ECFMG		OTHER
LICENSURE MADE BY		FLEX X	National Board		State Exam		LMCC
7/92	Scores Received 79						
MEDICAL SCHOOL	U. California						
1 US		Canada		Foreign		Offshore		Fifth Path
1	Transcripts Rcvd		Translations Rcvd		1990	Degree Rcvd	
POST GRADUATE TRAINING		1 Year		X 2 Years			
7/15	GROUP HEALTH 6/90-7/92						

STATE LICENSE VERIFICATION

HOSPITAL PRIVILEGES VERIFICATION

STAFF DECISION 9/23/92

X	Approved: Beverly A Hufford	Date: 9-15-92
	Further Review Required by Board:	Date:

BOARD DECISION			Date:
	Approved		Disapproved

BOARD COMMENTS

4/18/91

NAME KAMINSKI, ANNA WILDY

FORMER NAME

DATE ADMITTED 06-17-85

BIRTHDATE 05-22-59
BIRTHPLACE NEW YORK

M AS OF 08-16-90 01

MEDICINE
4

ADMISSION CREDENTIALS
VASSAR C AB 1982

SUBJECT A

AMERICAN HIST

AMERICAN INST

GRADUATION
MD 06-17-90

UCB/UCSF JOINT MEDICAL PROGRAM

PHYSIOLOGY 208 SATIS
PHARMACOL 100A-B

DEPARTMENT COURSE	UNITS	GRD	CODES
SUMMER 1985			
BIOCHEM S102	6.00	P	2
HL MED SCI S247	6.00	P	2
UNITS COMPLETED	12.00		
FALL 1985			
ANATOMY 205	10.50	P	2
ANATOMY 210	3.00	P	2
HL MED SCI 248A	3.00	P	2
HL MED SCI 292	1.50	P	2
HL MED SCI 298	1.50	P	2
HL MED SCI 298	1.50	P	2
HL MED SCI 298	1.50	P	2
HL MED SCI 298	1.50	P	2
MICROBIOL 103	4.50	P	2
PHYSIOLOGY 100B	7.50	P	2
UNITS COMPLETED	36.00		
SPRING 1986			
ANATOMY 105	6.00	P	2
BIO ENV HL 105	6.00	P	2
BIO ENV HL 160	3.00	P	2
HL MED SCI 210	3.00	P	2
HL MED SCI 227	3.00	P	2
HL MED SCI 248B	6.00	P	2
SOC ADM HL 261	3.00	P	2
SOC ADM HL 290	4.50	P	2
UNITS COMPLETED	34.50		
SUMMER 1986			
PHYSIOL S208	12.00	P	2
UNITS COMPLETED	12.00		
FALL 1986			
BIO ENV HL 104	3.75	P	2
HL MED SCI 205A	3.00	P	2
HL MED SCI 206A	4.50	P	2
HL MED SCI 208	6.00	P	2
HL MED SCI 209A	6.00	P	2
HL MED SCI 292	1.50	P	2
UNITS COMPLETED	24.75		
SPRING 1987			
ANATOMY 203	6.00	P	2
HL MED SCI 206B	4.50	P	2
HL MED SCI 209B	6.00	P	2
HL MED SCI 211	4.50	P	2
SOCIOLOGY 280L	4.50	P	2
UNITS COMPLETED	25.50		
FALL 1987			
HL MED SCI 205B	3.00	P	2
HL MED SCI 206C	4.50	P	2
HL MED SCI 260A	3.00	P	2
HL MED SCI 298	3.00	P	2
SOCIOLOGY 163	6.00	P	2
UNITS COMPLETED	19.50		
WINTER 1988			
PSYCHIATRY 180	2.00	P	
UNITS COMPLETED	2.00		
SPRING 1988			
EP INTL HL 100	2.00	P	
HL MED SCI 206D	4.50	P	2
HL MED SCI 260B	3.00	P	2
PUB HLTH 288	4.50	P	2
UNITS COMPLETED	14.00		
SS 3 1988			
NEUROLOGY 110	6.00	P	
PSYCHIATRY 135	.00	P	
PSYCHIATRY 135	.00	P	
SURGERY 110	12.00	P	
UNITS COMPLETED	18.00		
FALL 1988			
OB GYN R S 110	9.00	P	
PEDIATRICS 110	9.00	P	
PSYCHIATRY 135	.00	P	
PSYCHIATRY 135	.00	P	
UNITS COMPLETED	18.00		
WINTER 1989			
MEDICINE 110	12.00	P	
PSYCHIATRY 110	6.00	P	
PSYCHIATRY 135	.00	P	
UNITS COMPLETED	18.00		
SPRING 1989			
ANESTHESIA 110	3.00	P	
MEDICINE 140.22C	6.00	P	
MEDICINE 140.35	6.00	P	
UNITS COMPLETED	15.00		
SUMMER 1989			
FAM CM MED 110	6.00	P	
MEDICINE 140.01	6.00	P	
PEDIATRICS 140.02	6.00	P	
UNITS COMPLETED	18.00		
FALL 1989			
FAM CM MED 110	6.00	P	
MEDICINE 140.13	6.00	P	
SURGERY 111	6.00	P	
UNITS COMPLETED	18.00		
WINTER 1990			
SURGERY 140.02	6.00	P	
UNITS COMPLETED	6.00		
SPRING 1990			
MEDICINE 111	3.00	P	
MEDICINE 112	3.00	P	
RADIOLOGY 140.09	6.00	P	
UNITS COMPLETED	12.00		
SUMMARY TO DATE			
UNITS COMPLETED	303.25		

Department of Health

AUG 27 1990

Licensing and Certification
Asst. Secretary

MEDICAL EXAMINER'S

AUG 27 1990

RCVD

AUG 22 1990

NOT OFFICIAL WITHOUT SIGNATURE SEAL

UNIVERSITY OF CALIFORNIA
SAN FRANCISCO

REGISTRAR AND ADMISSIONS OFFICE

PSC F88-0102

D 2 KAMINSKI, ANNA WILDY

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

ENDORSEMENT OF CERTIFICATION

MEDICAL UNIT

JUL 06 1992

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OF THE
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Anna Wildy Kaminski, M.D.

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Chairman of the Board

SEAL Robert L. Volle, PhD
President of the Board

Philadelphia, Pa.
07/01/91

Certificate # 371761

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Psychiatry	370	76
TOTAL TEST(Minimum Passing Score 290/75)	465	80
PART III passed 03/91		
A General Test of Clinical Competence		
TOTAL TEST(Minimum Passing Score 290/75)	505	82

GENERAL AVERAGE (Parts, I, II, and III Scale Score) 79

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

SEE OTHER SIDE FOR SCORE INFORMATION

Melanie Valente
Secretary for Certification

SEAL

06/29/92
Date

INTERPRETATION OF SCORES

STANDARD SCORES

Part I and Part II Examinations Passed Prior to June 1991

Total test score **and** subject scores are reported. The total test score is based on the number of questions answered correctly on the entire examination and is nct the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Part I Examination - June & September 1991 Part II Examination - September 1991 & April 1992

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All Part III Examinations

Only total test score is reported. The total test score is based on the total number of questions answered correctly on the entire examination. Scores are reported on a scale with a mean of 500 and a standard deviation of 100, in increments of 5.

SCALE SCORES

For all examinations, the scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

Group Health Cooperative
of Puget Sound

200 - 15th Avenue East Seattle, WA 98112 (206) 326-3585 Family Practice Residency

June 24, 1992

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

To Whom It May Concern:

This letter is to verify that Anna Kaminski, MD, is a resident in good standing, who will be completed her second year of residency training in our Family Practice Residency Program on June 30, 1992, and will start the third year of training on July 1, 1992.

If you have any questions, please call me at 326-3585.

Sincerely,

MJ Wanderer MD

Michael J. Wanderer, M.D.
Director
Family Practice Residency

Health

Board of Medical Examiners
1300 SE Quince St.
Olympia, WA 98504-7866
206-753-2999 or 753-2205

MEDICAL UNIT

JUL 28 1992

RECEIVED

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

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

ANNA N. KAMINSKI — APPLICANT (PRINT OR TYPE)

5-22-59 — BIRTHDATE

Anna N. Kaminski — SIGNATURE OF APPLICANT

TO: Department of Health
Board of Medical Examiners
1300 SE Quince St., EY-25
Olympia, WA 98504

July 21, 1992 — DATE

1. Anna Kaminski is or was engaged in post-graduate training in our program from 7/1/91 (BEGINNING DATE) to 6/30/92 (ENDING DATE).
in the field of Family Practice.

2. Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evaluations conducted.) Excellent physician & Excellent knowledge base, good communication skills, hard worker,

3. Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☐ No If yes, please explain

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

5. We would appreciate any further documentation you feel would assist in the evaluation process. Thank you.

(Seal)

Signature [signature]
Title [signature]
Hospital Group Health Cooperative
PLEASE TYPE OR PRINT
Address 200 15th Ave E, CHE107
Seattle, WA 98112
Date July 21, 1992

DOH 657-034 (Rev. 3/91)

Health

RECEIVED
JUN 25 1992

TO THE APPLICANT

Complete the identifying information below and submit to:

Federation of State Medical Boards
6000 Western Place, Suite 707
Fort Worth, Texas 76107

MEDICAL UNIT
JUL 02 1992
RECEIVED

Attention: Barbara Rains
Board Inquiry Specialist

Department of Health
Board of Medical Examiners
1300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504-7866

Date:

Dear Ms. Rains:

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

NAME: ANNA W. KAMINSKY KAMINSKI

SSN: 1 - DOH Licensee Social Security Number - ...

MEDICAL SCHOOL OF GRADUATION: UCSF

YEAR OF GRADUATION: ~~1990~~

BIRTHDATE: 5-22-59

RESPONSE:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

JUN 29 1992

James R. Winn, M.D.

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

DOH 657-072 (Rev. 02/92))

AMA PHYSICIAN PROFILE

MEDICAL UNIT

AMERICAN MEDICAL ASSOCIATION
515 NORTH STATE STREET
CHICAGO, ILLINOIS 60610

JUL 10 1992

RECEIVED

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF PHYSICIAN DATA SERVICES

DATE: 07-02-92
TIME: 6:16 PM

NAME: KAMINSKI,ANNA WILDY, M.D.
ADDRESS: GROUP HLTH COOPERATIVE
SEATTLE WA 98112
BIRTHPLACE: NEW YORK,NY
BIRTHDATE: 05/22/59
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL: 005-02
UNIV OF CA, SAN FRANCISCO, SCH OF MED, SAN FRANCISCO-CA 94143
YEAR OF GRADUATION: 1990
LICENSES (INITIAL YEAR GRANTED BY STATE):
NONE REPORTED TO DATE
NATIONAL BOARD CERTIFICATION: 1991
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: RESIDENT
SELF DESIGNATED SPECIALTIES
PRIMARY: FAMILY PRACTICE
SECONDARY: UNSPECIFIED
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: INTERN
HOSPITAL: GROUP HLTH COOP/PUGET SOND SEATTLE WA 98112
DATES OF TRAINING: 07/90-06/93 -- (BEING RE-CONFIRMED)
SPECIALTY: FAMILY PRACTICE
SPECIALTY: UNSPECIFIED

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

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

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

COPYRIGHT 1992 AMERICAN MEDICAL ASSOCIATION. SEE REVERSE. ****AMA FILES CHECKED

20

AMA PHYSICAN PROFILE (CONTINUED)

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

August 12, 1992

Anna Kaminski, MD
523 N 48th St
Seattle, WA 98103

Dear Dr. Kaminski

As of this date, our records indicate the following items still have not been received. In order for us to continue processing your application we will need the following documents:

MDB clearance
National board scores

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

If you have any questions, please contact me at (206) 753-2205.

Sincerely,

Betty Elliott
Program Representative

MEDICAL BOARD WORKSHEET

"Limited License"

Name KAMINSKI, Anna Wildy Date of Birth 5 (Month) 22 (Day) 59 (Year)

☐ FELLOWSHIP ☐ TEACHING/RESEARCH ☒ RESIDENCY

☒ FEE REC'D ☒ PHOTO ☒ AFFIDAVIT

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

☒ CHRONOLOGY Missing_____ to_____

☒ MEDICAL SCHOOL TRANSCRIPTS 4/13/90

☒ VERIFICATION OF EMPLOYMENT (Dates) 6-25-90 to_____

☐ LETTER OF APPOINTMENT VERIFYING LICENSURE IN ANOTHER STATE

☐ STATE CLEARANCE _____, _____, _____, _____

☐ POST GRADUATE TRAINING ☐ _____

☐ _____

☐ _____

☐ ECFMG

☐ AMA

☐ MDB

☒ Aids Education

☐ INSTITUTION_____

☐ STATE LICENSE_____

☐ COUNTY CITY HEALTH_____

☐ STATE LICENSE_____

Approved Katie L Kalthoff Disapproved_____ Date 9-1-90

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

STATE OF WASHINGTON

PROFESSIONAL LICENSING SERVICES

THIS CERTIFIES THAT THE PERSON NAMED HEREON IS AUTHORIZED AS PROVIDED BY LAW AS A

LIMITED PHYSICIAN - RESIDENT

REF # KA-MI-NA-W413K2
GROUP HEALTH COOPERATIVE
KAMINSKI,ANNA WILDY
GROUP HEALTH COOPERATIVE
SEATTLE WA 98112

Mary Faulk
DIRECTOR

NUMBER	ISSUED DATE	EXPIRATION DATE
252-14 FILE # 0003269	06-25-90	07-31-91

PERSONAL COPY OF YOUR LICENSE

REMOVE PERSONAL COPY FROM DISPLAY COPY

STATE OF WASHINGTON

REF # KA-MI-NA-W413K2
LIMITED PHYSICIAN CLASS R
GROUP HEALTH COOPERATIVE
KAMINSKI,ANNA WILDY
GROUP HEALTH COOPERATIVE
SEATTLE WA 98112

Mary Faulk
DIRECTOR

NUMBER	Expiration Date
252-14 FILE # 0003269	07-31-91

MEDICAL EXAMINER'S
MAY 22 1991
RCVD

Return with check or money order to ensure proper credit of your license application fee.

DEPOSIT CREDIT

Physician & Surgeon

ANNA KAMINSKI

NAME (Please Print)

DATE

DOH 657-079 (1/91)

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

☐ Check ☐ Money Order

$ 325.00

Please note amount enclosed, and return with your application.

225.00 Refund Requested

1A 0252090000 00237

000360 07/14/92 32500

Group Health Cooperative of Puget Sound

MEDICAL EXAMINER'S
MAY 22 1991
RCVD

200 - 15th Avenue East Seattle, WA 98112 (206) 326-3585 Family Practice Residency

May 6, 1991

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

Dear Ms. Bernal,

This letter is to verify that Anna Kaminski, M.D., is a resident in good standing, who will be completing her first year of residency training in our Family Practice Residency Program on June 28, 1991, and will start her second year of training on July 1, 1991.

If you have any questions, please call me at 326-3585.

Sincerely,

Michael J. Wanderer, M.D.
Director
Family Practice Residency

STATE OF WASHINGTON MEDICAL EXAMINER'S

DEPARTMENT OF licensing APR 12 1990 P.O. BOX 9649 OLYMPIA, WA 98504-8001

RCVD

FOR VALIDATION ONLY 026-070-252-0014

APPLICATION FOR
LIMITED LICENSE TO PRACTICE MEDICINE

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

☐ Institution ☐ County-City Health Dept. ☒ Internship-Residency
☐ Fellowship ☐ Teaching-Research

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

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME (20) KAMINSKI (Last) ANNA (First) WILDY (Middle)

ADDRESS (21) GROUP HEALTH COOPERATIVE
(INSTITUTION, MEDICAL SCHOOL, HOSPITAL, HEALTH DEPT.)

CITY (24) SEATTLE STATE (25) WA ZIP (26) 98112 COUNTY (27) KING

APPLICANT'S TELEPHONE NO. (39) (206) 722-7744
(Enter the number at which you can be reached during normal business hours)

APPLICANT'S SOCIAL SECURITY NO. (40) 1 - DOH Licensee Social...
(Requested for identification purposes only. Entering SSN voluntary and is not mandatory for licensing approval.)

SEX (F or M) F DATE OF BIRTH 5 (Mo) / 22 (Day) / 59 (Year)

OFFICE USE ONLY	
GRAD YR/SCH (48)	07 31 90
CERT DATE (44)	06 25 90
CERT NO (45)	03269

MEDICAL SPECIALTY FAMILY PRACTICE

INSTITUTION/HEALTH DEPT./MEDICAL SCHOOL/HOSPITAL:

(DBA-38) GROUP HEALTH COOPERATIVE

INSTRUCTIONAL OR FELLOWSHIP PROGRAM: INTERNSHIP

MEDICAL SCHOOL ATTENDED: UCALIFORNIA BERKELEY - UCALIFORNIA SAN FRANCISCO
(M.D. granted from UCSF)

YEAR OF GRADUATION 1990

FOLLOW CAREFULLY ALL INSTRUCTIONS IN GENERAL INSTRUCTIONS—ALL APPLICANT' THE RESPONSIBILITY OF THE APPLICANT TO SUBMIT OR REQUEST TO HAVE SUBMI REQUIRED SUPPORTING DOCUMENTS.

IDENTIFICATION

HEIGHT	WEIGHT
5'4"	115"
COLOR OF EYES	COLOR OF HAIR
BR	BR

1-20-00

Anna V. Kaminski

NOTICE TO APPLICANTS: ALL PERSONS LICENSED UNDER THIS SECTION SI SDICTION OF THE MEDICAL DISCIPLINARY BOARD TO THE SAME EXTENT AS OTHER ME SSION. IN ACCORDANCE WITH CHAPTERS 18.72 AND 18.130 RCW.

PERSONAL DATA

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

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

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

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

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

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

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

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

EDUCATION

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

(ATTACH ADDITIONAL 8½ x 11 SHEET IF NECESSARY)

SCHOOLS ATTENDED—LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.	NUMBER OF YEARS ATTENDED	ATTENDANCE				DIPLOMA OR DEGREE OBTAINED QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH
		ENTRANCE		LEAVING		
		CLASS/ GRADE	DATE MO./YR.	CLS/GRD CMPLT.	DATE MO./YR.	
Medical Education (List all Medical Schools Attended)						U.C.B MASTER OF SCIENCE
U.C. Berkeley - U.C. San Francisco	5	I	6/85	IV	5/90	~~U.C.B~~ IN HEALTH AND MEDICAL SCIENCES UCSF M.D.
Post-Graduate Training (List all programs attended)						

PREVIOUS LICENSURE

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

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

PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience. Include college, university, medical or osteopathic schoo. and ALL periods of time from the date of graduation from medical school to the present whether or not engaged in activitie related to medicine. (attach additonal 8½ x 11 sheet if necessary)

From.....To Month, Day, Year		Name and Location of Institution, Place of Practice or Other	Degree or Certificate and Date Received, or Nature of Experience or Specialty
9/77	12/81	VASSAR COLLEGE	B.A. 1982
6/85	6/88	U.C. BERKELEY	M.S. 1988
6/88	5/90	U.C. SAN FRANCISCO	M.D. 1990

KAMINSKI, ANNA MD00030198 AND ML20003269 PAGE 24

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

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

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

AFFIDAVIT

I, ANNA WILDY KAMINSKI, being first duly sworn, depose and say that
PRINT OR TYPE FULL NAME OF APPLICANT

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

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

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

Signature of applicant Anna Kaminski M.S.

(SEAL)

OFFICIAL SEAL
LEONA FEIST
NOTARY PUBLIC - CALIFORNIA
City & County of San Francisco
MY COMMISSION EXP. SEPT. 18,1992

Subscribed and sworn to before me

this 9th day of April, 19 90

Leona Feist

Notary Public for Co. of San Francisco

My commission expires: Sept 18, 1992

KAMINSKI, ANNA MD00030198 AND ML20003269 PAGE 25

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

RECEIVED
APR 12 1990
DEPT. OF HEALTH

CERTIFICATION OF COMPLETION
AIDS EDUCATION AND TRAINING

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

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

PLEASE PRINT OR TYPE
Applicant Name KAMINSKI (LAST) ANNA (FIRST) WILDY (MIDDLE)

Street Address 9136 SPEAR PL. S.

City SEATTLE State WA ZIP 98118

Date of Birth 5 / 22 / 59

Profession for which I am now applying FAMILY PRACTICE RESIDENCY, M.D.

I certify that I have received 4 hours of AIDS education and training through UNIVERSTY OF CALIFORNIA, SAN FRANCISCO (ORGANIZATION, COLLEGE, UNIVERSITY, ETC.) on 11/15/89 - 12/15/89 (DATE)

which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations, and have attached a certificate of attendance.

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

Anna Kaminski M.S. (SIGNATURE) 4/6/90 (DATE)

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

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

VERIFICATION OF AIDS EDUCATION
CURRICULUM CONTENT

APPLICANT: Please complete top portion and forward to college, university, etc. If your name has changed since attending, please include the one under which your records are filed.

PLEASE PRINT OR TYPE
Applicant Name KAMINSKI (LAST) ANNA (FIRST) WILDY (MIDDLE)

Date of Birth 5 / 22 / 59 Social Security Number 1 - DOH Licensee Social Security Numb... (TO ASSIST THE SCHOOL IN LOCATING YOUR RECORDS)

Profession for which I am applying RESIDENT IN FAMILY PRACTICE, MEDICAL DOCTOR

REGISTRAR, DEPARTMENT HEAD: The above applicant is required to provide verification of AIDS Education and Training for a minimum of 4 hours in the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and psychosocial issues to include special population considerations. The training must have been received after January 1, 1987. Please complete the form below and return to:

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

Thank you for your assistance.

PLEASE PRINT OR TYPE
Applicant Name Kaminski (LAST) Anna (FIRST) - Wildy (MIDDLE) -

Dates of AIDS education and training Nov 13 - December 10, 1989

Contact hours 160

I certify that the above individual received the stated hours in the topics outlined for AIDS education and training while enrolled in this program and that the requirement was met after January 1, 1987.

Name Emilie [illegible] M.D.

Title Associate Dean

SCHOOL SEAL

School/Program UCSF School of Medicine

In State Of California

MED-667-073 AIDS ED/TRAIN CERTIVER 7-8 09/2/89 Page 3 of 3

Date April 6, 1990

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

4252 002 050 032790 145.00

This is to certify that Anna Wildy Kaminski has been

appointed as a resident* in Family Practice (Service) at

the Group Health Cooperative of Puget Sound hospital for the period

beginning June (Mo) 25th (Day) 1990 (Year). The individual

responsible for this resident's patient care activities will be

Director of Program
(Signature)

*Resident physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.055 and is serving a period of postgraduate clinical medical training sponsored by a college or university in this state or by a hospital accredited by this state. The term shall include individuals designated as intern or medical fellow.

HOSPITAL SEAL

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

Need transcript w/ degree
date posted then will
approve

MEDICAL EXAMINER'S

APR 13 1990

RCVD

NAME KAMINSKI, ANNA WILDY
FORMER NAME

DATE ADMITTED 06-17-85
BIRTHDATE 05-22-59
BIRTHPLACE NEW YORK

M AS OF 03-02-90 01
MEDICINE
4

ADMISSION CREDENTIALS
VASSAR C AB 1982

SUBJECT A
AMERICAN HIST
AMERICAN INST

GRADUATION

UCB/UCSF JOINT MEDICAL PROGRAM

PHYSIOLOGY 208 SATIS
PHARMACOL 100A-B

DEPARTMENT COURSE	UNITS	GRD	CODES
SUMMER 1985			
BIOCHEM S102	6.00	P	2
HL MED SCI S247	6.00	P	2
UNITS COMPLETED	12.00		
FALL 1985			
ANATOMY 205	10.50	P	2
ANATOMY 210	3.00	P	2
HL MED SCI 248A	3.00	P	2
HL MED SCI 292	1.50	P	2
HL MED SCI 298	1.50	P	2
HL MED SCI 298	1.50	P	2
HL MED SCI 298	1.50	P	2
HL MED SCI 298	1.50	P	2
MICROBIOL 103	4.50	P	2
PHYSIOLOGY 100B	7.50	P	2
UNITS COMPLETED	36.00		
SPRING 1986			
ANATOMY 105	6.00	P	2
BIO ENV HL 105	6.00	P	2
BIO ENV HL 160	3.00	P	2
HL MED SCI 210	3.00	P	2
HL MED SCI 227	3.00	P	2
HL MED SCI 248B	6.00	P	2
SOC ADM HL 261	3.00	P	2
SOC ADM HL 290	4.50	P	2
UNITS COMPLETED	34.50		
SUMMER 1986			
PHYSIOL S208	12.00	P	2
UNITS COMPLETED	12.00		
FALL 1986			
BIO ENV HL 104	3.75	P	2
HL MED SCI 205A	3.00	P	2
HL MED SCI 206A	4.50	P	2
HL MED SCI 208	6.00	P	2
HL MED SCI 209A	6.00	P	2
HL MED SCI 292	1.50	P	2
UNITS COMPLETED	24.75		
SPRING 1987			
ANATOMY 203	6.00	P	2
HL MED SCI 206B	4.50	P	2
HL MED SCI 209B	6.00	P	2
HL MED SCI 211	4.50	P	2
SOCIOLOGY 280L	4.50	P	2
UNITS COMPLETED	25.50		
FALL 1987			
HL MED SCI 205B	3.00	P	2
HL MED SCI 206C	4.50	P	2
HL MED SCI 260A	3.00	P	2
HL MED SCI 298	3.00	P	2
SOCIOLOGY 163	6.00	P	2
UNITS COMPLETED	19.50		
WINTER 1988			
PSYCHIATRY 180	2.00	P	
UNITS COMPLETED	2.00		
SPRING 1988			
EP INTL HL 100	2.00	P	
HL MED SCI 206D	4.50	P	2
HL MED SCI 260B	3.00	P	2
PUB HLTH 288	4.50	P	2
UNITS COMPLETED	14.00		
SS 3 1988			
NEUROLOGY 110	6.00	P	
PSYCHIATRY 135	.00	P	
PSYCHIATRY 135	.00	P	
SURGERY 110	12.00	P	
UNITS COMPLETED	18.00		
FALL 1988			
OB GYN R S 110	9.00	P	
PEDIATRICS 110	9.00	P	
PSYCHIATRY 135	.00	P	
PSYCHIATRY 135	.00	P	
UNITS COMPLETED	18.00		
WINTER 1989			
MEDICINE 110	12.00	P	
PSYCHIATRY 110	6.00	P	
PSYCHIATRY 135	.00	P	
UNITS COMPLETED	18.00		
SPRING 1989			
ANESTHESIA 110	3.00		NR
MEDICINE 140.22C	6.00		P
MEDICINE 140.35	6.00		P
UNITS COMPLETED	12.00		
SUMMER 1989			
FAM CM MED 110	6.00		IP
MEDICINE 140.01	6.00		P
PEDIATRICS 140.02	6.00		P
UNITS COMPLETED	12.00		
FALL 1989			
FAM CM MED 110	6.00		P
MEDICINE 140.13	6.00		P
SURGERY 111	6.00		NR
UNITS COMPLETED	12.00		
WINTER 1990			
SURGERY 140.02	6.00		NR
UNITS COMPLETED	.00		
SUMMARY TO DATE			
UNITS COMPLETED	270.25		

REGISTRAR

APR 9 1990

NOT OFFICIAL WITHOUT SIGNATURE SEAL

UNIVERSITY OF CALIFORNIA
SAN FRANCISCO

REGISTRAR AND ADMISSIONS OFFICE

PSC F86-4102

B 2 KAMINSKI, ANNA WILDY

PRINT YOUR NAME AND ADDRESS

NAME — LAST: KAMINSKI FIRST: ANNA MIDDLE: W

ADDRESS: 9136 SPEAR PL. S.
SEATTLE WA 98118

SSN [1 - DOH Licensee Social Security Number - RCW 42.56.350(1)] BIRTHDATE 5 (MO) / 22 (DAY) / 59 (YR) NUMBER OF COPIES 1

SCHOOL/LEVEL GRAD ACAD MAJOR MEDICINE CURRENTLY ENROLLED? Y

FORMER NAME IF APPLICABLE _____ GRAD DATE 5/25/90

TO: Ms. Patti Rathburn
State of Washington
Board of Medical Examiners.
P.O. Box 1099
OLYMPIA WA 98507-1099

PRINT PLAINLY FOR WINDOW ENVELOPE

RAO-246 4/89

UCSF TRANSCRIPT REQUEST

MEDICAL EXAMINER'S

HOLD FOR: ☐ GRADE CHANGE ☐ DEGREE POSTING ☐ NAME CHANGE ☐ GRADES _____ QTR.

APR 13 1990

RCVD

RELEASE HOLD BY: _____

SIGNATURE Anna W Kaminski

DATE 4-6-90

OTHER _____

RECEIVED

APR 13 1990

DEPT. OF HEALTH

DATE MAILED _____

...STINE M. GEBBIE
...retary

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Board of Medical Examiners
P.O. Box 1099 • MS: EY-17 • Olympia, Washington 98507-1099 • (206) 753-2844

July 2, 1990

Anna Wildy Kaminski, MD
Group Health Cooperative
Seattle, WA 98112

Dear Dr. Kaminski:

This is to acknowledge receipt of your application to practice medicine in the state of Washington. According to our initial review and the documents in your file, the following items have not been received or insufficient:

1) **Transcripts from UCSF with degree date. The transcripts we received did not indicate date of degree.**

Upon receipt of the above mentioned items, your application will be considered completed and will again be forwarded for review.

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

Sincerely,

Beverly A. Gifford
Administrative Assistant
(206) 753-2844

LIMITED PHYSICIAN

Anna Kaminski

DEPT OF HEALTH
REVENUE SECTION

1 025214 00337

001647 05/21/91 22500

Application File_859919_pdf-r.pdf redacted on: 5/18/2017 09:58

Redaction Summary (7 redactions)

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1 Privilege / Exemption reason used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (7 instances)

Redacted pages:

Page 3, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 8, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 13, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 22, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 27, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 30, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 31, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance