# MEDICAL APPLICATION CHECKLIST

NAME: Bowers, Mark Thomas DOB: 1/18/58

☑ Fee Recd ☑ Photo ☑ Affidavit
☑ Personal Data: Yes Response To # ______ ______ ______ ______
☑ Chronology: Missing ______ TO ______ ______ TO ______ ______ TO ______

**TRAINING:**
☑ U.S. ☐ Canada ☐ Offshore ☐ Fifth Pathway ☐ Foreign
☐ ECFMG Cert (indefinite) ☑ AIDS education affidavit
☑ AMA Profile ☑ MDB Clearance

**REQUESTING LICENSURE BY:** ☐ Flex Exam ☐ June ______ ☐ December ______
☐ Flex Waiver Scores ______ ______ OR Wtd Ave ______
☑ Nat'l. Board Waiver Scores 85.4 ______ ______
☐ State Const. Exam From ______ Scores ______ ______ ______
☐ Reciprocity From ______ ☐ LMCC Cert. (After 1969)

**EDUCATION:**
Medical School University of Minnesota
M.D. Degree Date 1986 ☑ Transcript ☐ Translation

**POST GRADUATE TRAINING:** ☐ One year prior to 1985 ☑ Two years after 1985
☑ University of Washington 6/86 - present (6/90) ☑ Verif. ☑ Eval.
☐ ______ ☐ Verif. ☐ Eval.
☐ ______ ☐ Verif. ☐ Eval.
☐ ______ ☐ Verif. ☐ Eval.
☐ ______ ☐ Verif. ☐ Eval.
☐ Fifth Pathway verif. and Eval.

**STATE(S)/PROVINCES/COUNTRIES OF LICENSURE**
☐ ______ ☐ ______ ☐ ______ ☐ ______ ☐ ______ ☐ ______

**HOSPITAL PRIVILEGES (EXPERIENCE)**
☐ ______ ☐ ______
☐ ______ ☐ ______
☐ ______ ☐ ______

**OFF-SHORE CLERKSHIPS:**
☐ U.S. Enter institutions above under PGT ☐ Syllabus ☐ Contract
☐ State Board verif. in state(s) of ______ ______ ______
☐ Offshore Med. School ☐ Verif. of subject areas
☐ Eval. from Med School Dean ☐ Verif. from local jurisdiction

**ACTION:**
Refer to PPMD. Date ______ Ret'd. Date ______
Approved ☐ By ______ Date ______
Disapproved ☐ By ______ Date ______

To ensure receipt of your annual renewal notice and other timely information, please keep the Medical Quality Assurance Commission informed of any change in your name or address.

# Name and/or Address Change Form

(Please type or print in ink)

MD27147

License # WA 025209 Social Security # 2 - DOH Licensee Social Security Number - RCW 42.5...

☒ MD ☐ PA ☐ PA-C ☐ PA-SA

OCT 28 1998
Section 5

**Old Information:**

Name Mark T. Bowers, MD

Address 1145 Broadway

Seattle, WA 98122

**Changes:**

Name* Marci Lee Bowers MD

Address Same address

Had been changed on 7/13/98

*A change in name must be accompanied by a photocopy of the marriage certificate, the divorce decree, or the court-ordered name change (whichever is applicable).

Effective Date 6/29/98 Signature Marci Bowers

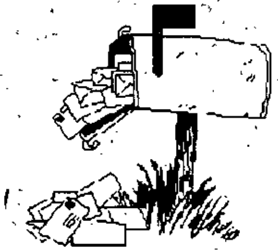
A licensee's address is open to public disclosure under circumstances defined in law, RCW 42.17. The address the Commission has on file for you is used for all mailings, renewal notification and public disclosure.

Cut out and mail this completed form to the commission office:

Medical Quality Assurance Commission
1300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504-7866

Attention: Address/Name Change

Please send info re: change in license / Diploma if possible! Thank you! MB.



Marci L. Bowers, M.D.
Obstetrics & Gynecology

**King County District Court**
**State of Washington**
**Bellevue Division**
**585 112th Ave SE**
**Bellevue, Washington 98004**
4612-00002

## ORDER CHANGING NAME

**In the matter of the Petition of** )
)
MARK THOMAS BOWERS ) **No.** CHN 98140
)

---

**The Petition of the above-named person for an order changing his/her present name, came regularly to be heard this date; the court having heard the evidence and it appearing to the satisfaction of the court that the allegations of the Petition for Change of Name are true; now therefore, it is hereby**

**ORDERED, ADJUDGED AND DECREED that the name of** MARK THOMAS BOWERS

**be changed to** MARCI LEE BOWERS.

**DONE IN ~~OPEN COURT~~ this** 20 **day of** May, **19**98.

[signature]
**JUDGE/COURT COMMISSIONER**

**Presented by:**

[signature: Mark Thomas Bowers]
**Pro Se**

1 - DOH Licensee Health Professional Home Address and/or Home Phone Number - R...

**Street Address**

1 - DOH Licensee Health Professional Home Address and/or Ho...

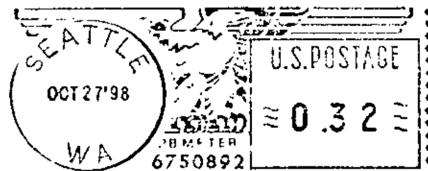
**City, State, Zip**

**(Order Changing Name)** **KCDCF #64/97**

**The Polyclinic**

1145 Broadway • Seattle, WA 98122-4299

ADDRESS SERVICE REQUESTED




Medical Quality Assurance Commission
1300 SE Quince Street
P.O. Box 47866
Olympia, WA
98504-7866

# The Polyclinic

Primary Care
Internal Medicine
Allergy & Immunology
Breast Disease/Surgery
Cardiology
Dermatology
Endocrinology
Gastroenterology
General Surgery
Infectious Disease
Nephrology
Neurology
Obstetrics & Gynecology
Occupational Medicine
Oncology & Hematology
Orthopedics
Otorhinolaryngology
Head & Neck Surgery
Plastic Surgery
Pulmonary Disease
Rheumatology
Thoracic Surgery
Tropical & Travel Medicine
Vascular Surgery
Urology
Clinical Laboratory
Surgery Center
X-Ray

27147

June 29, 1998

Washington State
Department of Health
Medical QA Commission
Attention: Mavis Pless
P.O. Box 47866
Olympia, Washington 98504-7866

DELIVERED
JUL 06 1998
Health Professions
Section 5

Re: Mark Bowers, M.D.
Washington License Number: 27147

Dear Mavis:

Dr. Bowers has applied for a name change through the King County District Court. The new name will be Marci Lee Bowers, M.D. Please change the name on the Washington State License to reflect this. Enclosed is a copy of the court order changing the name.

If you have any further questions please do not hesitate to contact me.

Sincerely,

Terry Reule
Terry Reule
Accounting Manager

Changed 7/13/98

**King County District Court**
**State of Washington**
**Bellevue Division**
**585 112th Ave SE**
**Bellevue, Washington 98004**
4612-00002

## ORDER CHANGING NAME

**In the matter of the Petition of** )
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MARK THOMAS BOWERS ) **No.** CHN 98140
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ORDERED, ADJUDGED AND DECREED that the name of MARK THOMAS BOWERS be changed to MARCI LEE BOWERS.

DONE IN ~~OPEN COURT~~ this 20 day of May, 19 98.

JUDGE/COURT COMMISSIONER

Presented by:

Mark Thomas Bowers
Pro Se

1 - DOH Licensee Health Professional Home Address and/or Home Phone Numb...
Street Address

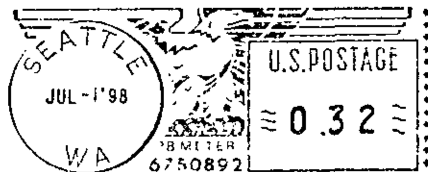
1 - DOH Licensee Health Professional Home Address and/or Home Pho...
City, State, Zip

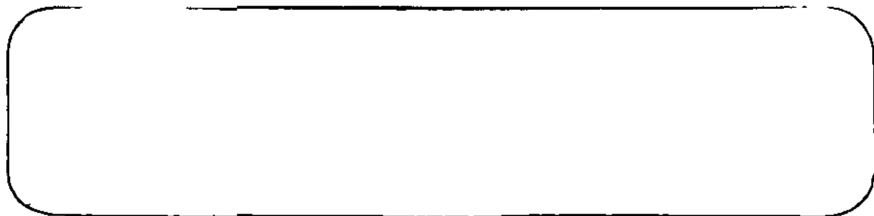
(Order Changing Name) KCDCF #64/97

The Polyclinic

1145 Broadway • Seattle, WA 98122-4299

FORWARDING AND ADDRESS CORRECTION REQUESTED



98504-7866

Rush

STATE OF WASHINGTON

DEPARTMENT OF Licensing

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

FOR VALIDATION ONLY 02G-070-252-0009

4095 000 050 110189 175.00

MAKE REMITTANCE PAYABLE TO: STATE TREASURER

# APPLICATION FOR LICENSE TO PRACTICE MEDICINE

FOR OFFICE USE ONLY

CERTIFICATE NO. 27147 ISSUE DATE 3/5/90 EXPIRATION DATE 1/18/91

APPLICATION FOR LICENSURE IS MADE BY: (check one)

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

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

FOR OFFICE USE ONLY

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

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

**PLEASE TYPE OR PRINT CLEARLY**

APPLICANT'S NAME (20) Bowers (LAST) Mark (FIRST) Thomas (MIDDLE)

ADDRESS (21) 2751 46TH Avenue SW

CITY (24) Seattle STATE (25) WA ZIP (26) 98116 COUNTY (27) King

TELEPHONE NUMBER (39) (206) 548-6190
WHERE YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.

SOCIAL SECURITY NUMBER (40) 2 - DOH Licensee Social Security Nu...
REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND IS NOT REQUIRED FOR LICENSING APPROVAL.

SEX (F or M) M BIRTHDATE 01 (MO.) 18 (DAY) 58 (YR.)

BIRTHPLACE Oak Park (CITY) Illinois (STATE) Cook (COUNTY)

MEDICAL SPECIALITY Obstetrics / Gynecology

MEDICAL SCHOOL University of Minnesota / USA (NAME/COUNTRY) YEAR GRADUATED 1986

FOR OFFICE USE ONLY

EXAM DATE (42)
VOTER DIST. (46)
GRAD. YR./SCH. (48)

HAVE YOU PREVIOUSLY APPLIED FOR A WASHINGTON STATE MEDICAL LICENSE OR LIMITED LICENSE? .......... [X] YES [X] 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' 11" | 145 # |
| COLOR OF EYES | COLOR OF HAIR |
| Green | Brown |

## 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.

| | YES | NO |
|---|---|---|
| 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.

| | YES | NO |
|---|---|---|
| 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.

| | YES | NO |
|---|---|---|
| 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**

REVIEWER: Patti DATE: 2-28-90

APPROVED: ✓ DISAPPROVED: ______

COMMENTS: Looks okay

# MEDICAL APPLICATION CHECKLIST

NAME: Bowers, Mark Thomas DOB: 1/18/58

☑ Fee Rec'd ☑ Photo ☑ Affidavit
☑ Personal Data: Yes Responses To # ______
☑ Chronology: Missing: ______ TO ______ ______ TO ______ ______ TO ______

**TRAINING:**

☑ U.S. ☐ Canada ☐ Offshore ☐ Fifth Pathway ☐ Foreign
☐ ECFMG Cert (indefinite) ☑ AIDS education affidavit
☑ AMA Profile ☑ MDB Clearance

**REQUESTING LICENSURE BY:** ☐ Flex Exam ☐ June ______ ☐ December ______

☐ Flex Waiver: Scores: ______ OR Wtd Ave. ______
☑ Nat'l. Board Waiver: Scores: 85.4
☐ State Const. Exam From ______ Scores: ______
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**EDUCATION:**

Medical School: University of Minnesota
M.D. Degree Date: 1986 ☑ Transcript ☐ Translation

**POST GRADUATE TRAINING:** ☐ One year prior to 1985 ☑ Two years after 1985

☑ University of Washington 6/86 - present (6/90) ☑ Verif. ☑ Eval.
☐ ______ ☐ Verif. ☐ Eval.
☐ ______ ☐ Verif. ☐ Eval.
☐ ______ ☐ Verif. ☐ Eval.
☐ ______ ☐ Verif. ☐ Eval.
☐ Fifth Pathway verif. and Eval.

**STATE(S)/PROVINCES/COUNTRIES OF LICENSURE**

☐ ______ ☐ ______ ☐ ______ ☐ ______ ☐ ______ ☐ ______

**HOSPITAL PRIVILEGES (EXPERIENCE)**

☐ ______ ☐ ______
☐ ______ ☐ ______
☐ ______ ☐ ______

**OFF-SHORE CLERKSHIPS**

☐ In U.S. Enter institutions above under PGT ☐ Syllabus ☐ Contract
☐ State Board verif. in state(s) of ______
☐ In Offshore Med. School: ☐ Verif. of subject areas
☐ Eval. from Med School Dean ☐ Verif. from local jurisdiction

**ACTION:**

Refer to PPMD. Date ______ Ret'd. Date ______
Approved ☑ By RPBurch MD Date 2-5-90
Disapproved ☐ By ______ Date ______

[illegible] MED. APP. CHECKLIST [illegible]

# LICENSES IN OTHER STATES/COUNTRIES

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

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

# AFFIDAVIT

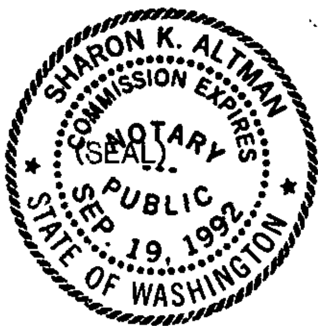
I, Mark Thomas Bowers, being first duly sworn, depose and say that
PRINT OR TYPE FULL NAME OF APPLICANT

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

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

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

Applicant's Signature Mark T Bowers




Subscribed and sworn to before me this 26

day of October, 19 89

Sharon K. Altman

Notary Public for the state of Washington

Residing at Mukilteo

# EDUCATION AND EXPERIENCE

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

| SCHOOLS ATTENDED—LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH. | NUMBER OF YEARS ATTENDED | ATTENDANCE | | | | DIPLOMA OR DEGREE OBTAINED QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH |
|---|---|---|---|---|---|---|
| | | ENTRANCE | | LEAVING | | |
| | | CLASS/ GRADE | DATE MO./YR. | CLS/GRD CMPLT. | DATE MO./YR. | |
| Medical Education (List all Medical Schools Attended) | | | | | | |
| University of Minnesota | 4 | | 9/82 | | 6/86 | M.D. |
| | | | | | | |
| Post-Graduate Training (List all programs attended) | | | | | | |
| University of Washington | 4 | | 6/86 | | 6/90 | OB/GYN Residency |
| | | | | | | |
| | | | | | | |

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

| INDICATE NATURE OF EXPERIENCE OR PRACTICE | INCLUSIVE DATES OF EXPERIENCE | |
|---|---|---|
| | BEGINNING MO./YR. | ENDING MO./YR. |
| See above | | |
| | | |
| | | |
| | | |
| | | |
| | | |

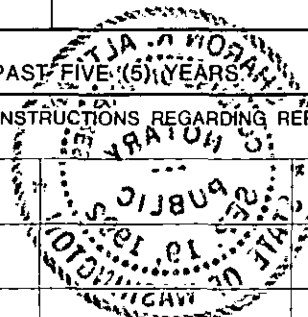
# FIFTH PATHWAY

(ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY)

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

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

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



| | | | |
|---|---|---|---|
| ~~U of Washington Medical Center~~ | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

PROCESSED: ______________

# MEDICAL BOARD WORKSHEET
## "LIMITED LICENSE"

NAME ______________________ DATE OF RECEIPT ____________

1. APPLICATION IN CONJUNCTION WITH:
   a) Institutions: [ ] ____________
      Name ____________ ____________
      State license ____________ ____________
   b) County-City Health Dept.: [ ] ____________
      Name ____________ ____________
      State license ____________ ____________
   c) Residency: UW [ ] ____________
      Hospital ____________ ____________
2. FEE: [✓] ______ VAL # ____________
3. PROOF OF EDUCATIONAL EXPERIENCE:
   a) Medical School Letter/Transcripts (Mailed Directly) Letter ______ Transcripts ______
   b) Verification of employment (Program) 6-25-86 Dates 7-31-87
   c) Certification of postgraduate training (Mailed Directly) [—] ____________
   d) ECFMG (Letter from ECFMG stating that applicant has standard certificate) [—] ____________
   e) Chronology [✓] ____________
4. PERSONAL DATA: [✓] ____________
5. AFFIDAVIT: ✓ PHOTOGRAPH: ✓ ____________
6. STATE CLEARANCE: Mld. ______ [—] ____________
7. AMA CLEARANCE: Mld. ______ [—] ____________

ADMINISTRATIVE RECOMMENDATION: ______________________

BOARD ACTION: APPROVED ✓
DISAPPROVED ______ DATE 9-18-86

PENDING ______________ REVIEWED BY: aar

MED-657-58 Ltd. Lic. Worksheet
(R/4/84) wpc

APPLICATION FOR

FEE . . . . . . . . . . . . . $55.00

Make remittance payable to:

STATE TREASURER

# LIMITED LICENSE TO PRACTICE MEDICINE

DEPARTMENT OF LICENSING
DIVISION OF PROFESSIONAL LICENSING
P.O. BOX 9649
OLYMPIA, WA 98504

VALIDATION ONLY

✓ 8051 070 051286 55.00

026-070-252-0014

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

☐ Institutions ☐ County-City Health Dept. ☒ Residency or Internship

FOR OFFICE USE ONLY

| PROG (1) | TRANS (3) | PROF CODE (4) | PIC/CIC (5) | | EXPIRATION DATE (9) | EXPT (10) | STAT (11) | TYPE (12) |
|---|---|---|---|---|---|---|---|---|
| LA | | 2521 | BO-WE-RM-T429BQ | 0 00-00-00 | | | | |
| KEY DATE (13) | CLASS | BOWERS,MARK THOMAS | | | SIGN | SPLIT | QTRD | |

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME (20) BOWERS (Last) MARK (First) THOMAS (Middle)

ADDRESS (21) 1474 SARGENT AV.

CITY (24) ST. PAUL STATE (25) MN ZIP (26) 55105 COUNTY (27) RAMSAY

NAME OF RESIDENCY PROGRAM/INSTITUTION OR CITY/COUNTY HEALTH DEPARTMENT . (DBA) (38)

UNIVERSITY OF WASHINGTON -- OBSTETRICS + GYNECOLOGY

Renewal.
EX. 9-31-89

APPLICANT'S TELEPHONE NO. (39)

(612) 690-0495

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

APPLICANT'S SOCIAL SECURITY NO. (40)

2 - DOH Licensee Social Security Number - RCW 42....

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

OFFICE USE ONLY
No. 2268
ID 6-25-86
Exp. 7-31-87
MLD. 9/29/86

R- 7/31/88

APPLICANT'S SEX (F or M) M DATE OF BIRTH 1 (Mo.) 18 (Day) 58 (Year)

PLACE OF BIRTH OAK PARK, ILLINOIS

MEDICAL SPECIALTY OBSTETRICS / GYNECOLOGY

OFFICE USE ONLY

GRAD YR/SCH (48)

## INSTRUCTIONS

ALL APPLICANTS

1. This application and supporting documents should be filed with the Division of Professional Licensing at least 60 days prior to the date of employment.
2. If additional space is required, attach separate (8½ x 11 inch) sheets indicating the section to which they refer.
3. FEES MUST ACCOMPANY ALL APPLICATIONS. FEES ARE NON-REFUNDABLE.

MED 657-056 Ltd. Lic. App. (Rev. 2/82) -305-

Specific Instructions are enclosed

3

## IDENTIFICATION

| HEIGHT | WEIGHT |
|---|---|
| 5' 11" | 140 # |
| COLOR OF EYES | COLOR OF HAIR |
| GREEN | BROWN |

## PERSONAL DATA

If any of the following questions are answered "Yes", full details must be furnished on a separate (8½ x 11 inch) sheet and attached to this application.

| Question | Yes | No |
|---|---|---|
| 1. Have you ever been called before any state board for interrogation concerning any violation of the laws or rules pertaining to the profession for which you are applying or unethical conduct? | ☐ | ☒ |
| 2. Have you ever been convicted of a felony or misdemeanor other than traffic violations? | ☐ | ☒ |
| 3. Have you ever been convicted of a violation of any state or federal Controlled Substances Act, or any drug or narcotic law? | ☐ | ☒ |
| 4. Have you ever had a license to practice revoked or suspended? | ☐ | ☒ |
| 5. Have you ever been addicted to or treated for addiction to any controlled substance? | ☐ | ☒ |
| 6. Have you ever received psychiatric treatment or received treatment for a mental illness? | ☐ | ☒ |
| 7. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism? | ☐ | ☒ |
| 8. Have you ever been denied the right to take an examination for licensing in any state? | ☐ | ☒ |
| 9. Are you presently suffering from any disability or illness which could affect your ability to safely practice medicine? | ☐ | ☒ |
| 10. List any malpractice actions that have been filed against you, including the nature of the case, date and address of court where it is filed, and case status. | ☐ | ☒ |

## PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience. Include college, university, medical or osteopathic school, and ALL periods of time from the date of graduation from medical school to the present whether or not engaged in activities related to medicine.

| 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 |
|---|---|---|---|
| 9/76 | 12/80 | UNIV. OF WISCONSIN - MADISON | B.S. |
| 9/82 | 6/86 | UNIV. OF MINNESOTA - MINNEAPOLIS | M.D. |
| | | | |
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| | | | |

## PREVIOUS LICENSURE

Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current;

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

AFFIDAVIT

I, Mark J. Bowers (print or type full name of applicant), being first duly sworn, depose and say that I am the person described and identified; that I am of good moral character; that I have not engaged in any of the acts prohibited by the statutes of the State of Washington, that I am the person named in the diploma which accomnpanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

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

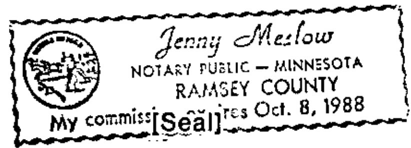
I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, 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. Subscribed and sworn to before me

this 5th day of May 19 86 Signature of applicant [signature]

Jenny Meslow

Norary Public for Ramsey County

My commission expires: Oct 8, 1988

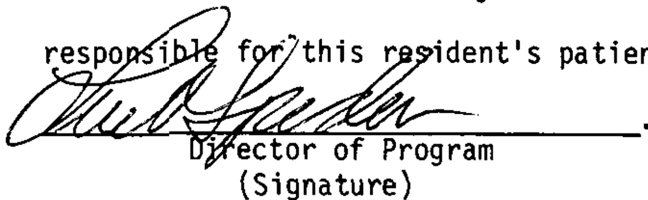


STATE OF WASHINGTON

# DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

This is to certify that MARK BOWERS has been appointed as a resident* in OBSTETRICS AND GYNECOLOGY (Service) at the UNIVERSITY OF WASHINGTON AFFILIATED hospital for the period beginning JUNE (Mo) 25 (Day) 1986 (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

RECEIVED
MAY 14 1986
DIVISION OF PROFESSIONAL LICENSING

DIVISION OF PROFESSIONAL LICENSING
MAY 13 1986
RECEIVED

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

STATE OF WASHINGTON
DEPARTMENT OF LICENSING
Highways-Licenses Building • Olympia, Washington 98504 • (206) 753-6918
Theresa Anna Aragón, *Director*

July 21, 1986

Univ. of Washington
Medical Director's Office
Mail Stop RD-30
Seattle, WA 98195

Elizabeth Lustig:

This is to inform you that the following physician(s) practicing under your residency/internship program still HAS NOT received his/her Washington State Limited License to practice medicine.

The submitted limited license application is pending the documentation listed next to the physician's name. (Each physician has been notified previously regarding this delinquent documentation.)

Please contact the below-named physician(s) and inform them of their application deficiencies.

The following applicants lack Medical School Transcripts after their degree has been awarded:

- Mark T. Bowers
- Sue A. Brenner
- Linda Chu
- Henry Gwinnell Coit Jr.
- Bonnie Sue Collins
- Aaron G. Filler (also, verif of employment program)
- Lorri Jan Fulkerson
- Miguel Angel Gomez
- Steven R. Hamilton
- Richard C. Hert
- Keith H. Leyden
- Merritt H. Raitt
- Steven S. Sasaki
- Brian Schnell
- Daniel A. Schleske
- Janine Shaw
- David L. Swerdlow

Continued on second page---

Thank you for your cooperation.

Sincerely,

Donna Hull

Donna Hull, Administrative Asst.
Health Care Licensing
P O Box 9649
Olympia, WA 98504
(206) 753-2999

ab

STATE OF WASHINGTON

# DEPARTMENT OF LICENSING

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

Theresa Anna Aragón, *Director*

6/2/86

Mark Bowers
1474 Sargent Ave.
St Paul, MN 55105

We received your limited medical license application and upon review find it tp be lacking the following documentation:

Medical school transcripts after degree has been awarded.

Upon receipt of the above, your application will be administratively reviewed for licensure.If you have questions or we can be of assistance, feel free to contact this office.

Sincerely,

Donna Hull
Administrative Assistant
Health Care Licensing
P O Box 9649
Olympia, WA 98504
(206)753-2999

STUDENT NAME
BOWERS MARK THOMAS

BIRTHDATE 01/18/58 | FILE NO 1194487 | SOC SEC NO 2 - DOH Licensee Social ...

STUDENT ADDRESS
1474 SARGENT AVE. SO.
ST. PAUL MN 55105

-------------CURRENT INFORMATION-------------

CAMPUS: TWIN CITIES | COLLEGE: MED SCH-TC | AREA:

MAJOR: MEDICINE | SUBPROGRAM: | DEGREE SOUGHT: MD

TELEPHONE: (612)690-0495

RES/CIT STA: RESIDENT/CITIZEN

HOLDS/DESCRIPTIONS/CLEARANCE ADDRESSES:
NO HOLDS ON RECORD
TRANSCRIPT LEVEL: PROFESSIONAL

TRACKING FLAGS/DESCRIPTIONS:
NO TRACKING FLAGS ON RECORD

---

FALL QUARTER 1982 MED SCH-TC
MAJOR: MEDICINE

| Course | Title | Credits | Grade |
|---|---|---|---|
| ANAT 5100 | GROSS HUMAN ANATOMY | 10.0 | S |
| ANAT 5103 | HUMAN HISTOLOGY | 6.0 | S |
| ANAT 5106 | HUMAN EMBROYOLOGY | 4.0 | E |
| MDBC 5100 | MEDICAL BIOCHEMISTR | 5.0 | O |

COMPL CRS: 25.0 QTR GPA: 0.00 CUM GPA: 0.00

WINTER QUARTER 1983 MED SCH-TC
MAJOR: MEDICINE

| Course | Title | Credits | Grade |
|---|---|---|---|
| ANAT 5111 | HUMAN NEUROANATOMY | 3.0 | S |
| MDBC 5101 | MEDICAL BIOCHEM | 5.0 | O |
| MICB 5205 | MICB FOR MED STUDEN | 5.0 | O |
| PHSL 5110 | HUMAN PHYSIOLOGY | 5.0 | S |

COMPL CRS: 18.0 QTR GPA: 0.00 CUM GPA: 0.00

SPRING QUARTER 1983 MED SCH-TC
MAJOR: MEDICINE

| Course | Title | Credits | Grade |
|---|---|---|---|
| INMD 5115 | CLIN CORRELATIONS | 3.0 | S |
| LAMP 5101 | GENERAL PATHOLOGY | 2.0 | E |
| MICB 5206 | MICB FOR MED STUDEN | 5.0 | O |
| PHSL 5111 | HUMAN PHYSIOLOGY | 6.0 | E |

COMPL CRS: 16.0 QTR GPA: 0.00 CUM GPA: 0.00

SUMMER SESSION I 1983 MED SCH-TC
MAJOR: MEDICINE

| Course | Title | Credits | Grade |
|---|---|---|---|
| ADPY 5107 | HUMAN BEHAVIOR | 4.0 | O |
| INMD 5100 | CLIN MEDICINE I | 5.0 | S |
| INMD 5110 | HUMAN GENETICS | 2.0 | S |
| INMD 5233 | HUMAN SEXUALITY | 2.0 | S |
| LAMP 5101 | GENERAL PATHOLOGY | 4.0 | E |

COMPL CRS: 17.0 QTR GPA: 0.00 CUM GPA: 0.00

FALL QUARTER 1983 MED SCH-TC
MAJOR: MEDICINE

| Course | Title | Credits | Grade |
|---|---|---|---|
| INMD 5101 | CLIN MEDICINE II | 4.0 | S |
| INMD 5201 | PATHOPHYSIOLOGY I | 12.0 | E |
| LAMP 5102 | ORGAN SYSTEM PATH | 4.0 | S |
| PHCL 5110 | PHARMACOLOGY | 5.0 | S |

COMPL CRS: 25.0 QTR GPA: 0.00 CUM GPA: 0.00

WINTER QUARTER 1984 MED SCH-TC
MAJOR: MEDICINE

| Course | Title | Credits | Grade |
|---|---|---|---|
| INMD 5202 | PATHOPHYSIOLOGY II | 11.0 | O |
| INMD 5203 | PATHOPHYSIOLOGY III | 11.0 | S |
| LAMP 5102 | ORGAN SYSTEM PATH | 4.0 | S |
| PHCL 5111 | PHARMACOLOGY | 4.0 | S |

COMPL CRS: 30.0 QTR GPA: 0.00 CUM GPA: 0.00

SPRING QUARTER 1984 MED SCH-TC
MAJOR: MEDICINE

| Course | Title | Credits | Grade |
|---|---|---|---|
| INMD 5102 | CLIN MED:INTERNAL M | 4.0 | S |
| INMD 5103 | CLIN MED:FAM PRACT | 4.0 | E |
| INMD 5104 | CLIN MED:PEDIATRICS | 4.0 | S |
| INMD 5105 | CLIN MED:NEUROLOGY | 4.0 | E |
| INMD 5204 | PATHOPHYSIOLOGY IV | 6.0 | E |

COMPL CRS: 22.0 QTR GPA: 0.00 CUM GPA: 0.00

SUMMER SESSION I 1984 MED SCH-TC
MAJOR: MEDICINE

| Course | Title | Credits | Grade |
|---|---|---|---|
| SURG 5500 | EXTERNSHIP:SURGERY | 9.0 | E |

COMPL CRS: 9.0 QTR GPA: 0.00 CUM GPA: 0.00

FALL QUARTER 1984 MED SCH-TC
MAJOR: MEDICINE MD
FREE TIME FALL 1984.

COMPL CRS: 0.0 QTR GPA: 0.00 CUM GPA: 0.00

ISSUED TO: MARK THOMAS BOWERS
1474 SARGENT AVE. SO.
ST. PAUL MN 55105

STUDENT NAME: BOWERS MARK THOMAS
BIRTHDATE: 01/18/58
FILE NO: 1194487
SOC SEC NO: 2 - DOH Licensee Social Sec...
TRANSCRIPT LEVEL: PROFESSIONAL

---

WINTER QUARTER 1985 MED SCH-TC
MAJOR: MEDICINE MD

| | | | | |
|---|---|---|---|---|
| OBST | 5500 | EXTERNSHIP:OBST | 9.0 | E |
| PED | 5501 | PEDIATRIC CLERKSHIP | 9.0 | O |

COMPL CRS: 18.0 QTR GPA: 0.00 CUM GPA: 0.00

SPRING QUARTER 1985 MED SCH-TC
MAJOR: MEDICINE MD

| | | | | |
|---|---|---|---|---|
| MED | 5500 | MED EXTERNSHIP I | 9.0 | S |
| NEUR | 5510 | EXTERNSH:CLIN PRACT | 9.0 | S |

COMPL CRS: 18.0 QTR GPA: 0.00 CUM GPA: 0.00

SUMMER SESSION I 1985 MED SCH-TC
MAJOR: MEDICINE MD

| | | | | |
|---|---|---|---|---|
| INMD | 5555 | ELECTIVE AWAY-CREDI | 4.5 | O |
| MED | 5525 | CARDIOVASC DISEASE | 9.0 | E |

COMPL CRS: 13.5 QTR GPA: 0.00 CUM GPA: 0.00

FALL QUARTER 1985 MED SCH-TC
MAJOR: MEDICINE MD

| | | | | |
|---|---|---|---|---|
| MED | 5501 | EXTERNSHIP IN MED | 9.0 | O |
| UROL | 5180 | EXTERNSHIP:UROLOGY | 4.5 | O |

COMPL CRS: 13.5 QTR GPA: 0.00 CUM GPA: 0.00

WINTER QUARTER 1986 MED SCH-TC
MAJOR: MEDICINE MD

| | | | | |
|---|---|---|---|---|
| INMD | 5500 | DIDACTIC/SELECTIVE | 9.0 | E |
| LAMP | 5187 | CLIN PATHOL EXTERN | 9.0 | E |

PAID M.D. GRADUATION FEE 03-03-86

COMPL CRS: 18.0 QTR GPA: 0.00 CUM GPA: 0.00

SPRING QUARTER 1986 MED SCH-TC
MAJOR: MEDICINE MD

| | | | | |
|---|---|---|---|---|
| ADPY | 5500 | PSYCHIATRY EXTERNSH | 9.0 | E |
| ANAT | 5509 | THE ABDOMEN | 4.5 | E |
| ANAT | 5510 | PERINEUM,GENITAL-UR | 4.5 | E |

COMPL CRS: 18.0 QTR GPA: 0.00 CUM GPA: 0.00

UNIVERSITY OF MINNESOTA SUMMARY INFORMATION

| | | | |
|---|---|---|---|
| UM CREDITS: | 261.0 | GPA CREDITS: | .0 |
| TRANSFER CRS: | .0 | GPA GRADE PTS: | .0 |
| TOTAL CREDITS: | 261.0 | UM CUM GPA: | 0.00 |

UNIT SUMMARY INFORMATION

| | | | |
|---|---|---|---|
| UNIT CREDITS: | 261.0 | GPA CREDITS: | .0 |
| GPA GRADE PTS: | .0 | UNIT CUM GPA: | 0.00 |

STATE OF WASHINGTON
**DEPARTMENT OF LICENSING**
Highways-Licenses Building • Olympia, Washington 98504 • (206) 753-6918
Theresa Anna Aragón, *Director*

6/2/86

Mark Bowers
1474 Sargent Ave.
St Paul, MN 55105

We received your limited medical license application and upon review find it tp be lacking the following documentation:

Medical school transcripts after degree has been awarded.

Upon receipt of the above, your application will be administratively reviewed for licensure.If you have questions or we can be of assistance, feel free to contact this office.

Sincerely,

Donna Hull

Donna Hull
Administrative Assistant
Health Care Licensing
P O Box 9649
Olympia, WA 98504
(206)753-2999

RECEIVED
DIVISION OF ... LICENSING

STATE OF WASHINGTON

# DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

This is to certify that Mark T. Bowers, M.D. has been appointed as a resident* in Obstetrics and Gynecology (Service) at the University of Washington Affiliated hospital for the period beginning July (Mo) 1 (Day) 87 (Year). The individual responsible for this resident's patient care activities will be

[signature]
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)

STATE OF WASHINGTON

REF # BU-WE-RM-T429BO

LIMITED PHYSICIAN CLASS R

UNIV OF WASH

BOWERS,MARK THOMAS

UNIV OF WASH

OB/GYN DEPT MS RD-30

MED DIR OFC

SEATTLE WA 98195

NUMBER Expiration Date

252-14 FILE # 0002268 07-31-87

STATE OF WASHINGTON

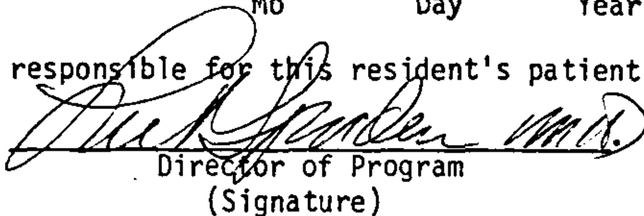
DEPARTMENT OF LICENSING
P.O. Box 9649, Olympia, Washington 98504

# CERTIFICATION OF RESIDENCY

This is to certify that Mark Thomas Bowers has been appointed as a resident* in Obstetrics and Gynecology at
Service

the University of Washington Affiliated hospital for the period beginning July 1 1988. The individual
Mo Day Year

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)

8194 000 070 100788 85.00

# STATE OF WASHINGTON

DIVISION OF PROFESSIONAL LICENSING

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

LIMITED PHYSICIAN - RESIDENT

REF # BO-WE-RM-T429BQ
UNIV OF WASH
BOWERS,MARK THOMAS
UNIV OF WASH
OB/GYN DEPT MS RD-30
MED DIR OFC
SEATTLE WA 98195

DIRECTOR

| NUMBER | ISSUED DATE | EXPIRATION DATE |
| --- | --- | --- |
| 252-14 FILE # 0002268 | 06-25-86 | 07-31-88 |

REMOVE BILLFOLD COPY FROM DISPLAY COPY

159 9-85

BILLFOLD COPY OF YOUR LICENSE

STATE OF WASHINGTON

REF # BO-WE-RM-T429BQ
LIMITED PHYSICIAN CLASS R
UNIV OF WASH
BOWERS,MARK THOMAS
UNIV OF WASH
OB/GYN DEPT MS RD-30
MED DIR OFC
SEATTLE WA 98195

DIRECTOR

| NUMBER | Expiration Date |
| --- | --- |
| 252-14 FILE # 0002268 | 07-31-88 |

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES    DATE: 02-19-90
DEPARTMENT OF PHYSICIAN DATA SERVICES    TIME: 3:59 PM

NAME: BOWERS,MARK THOS, M.D.
ADDRESS: 2751 46TH AVE SW
SEATTLE WA 98116
BIRTHPLACE: OAK PARK,IL
BIRTHDATE: 01/18/58
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL
UNIV OF MINNESOTA MED SCH-MINNEAPOLIS, MINNEAPOLIS MN 55455
YEAR OF GRADUATION: 1986
LICENSES (INITIAL YEAR GRANTED BY STATE):
NONE REPORTED TO DATE
NATIONAL BOARD CERTIFICATION: 1987
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: RESIDENT
SELF DESIGNATED SPECIALTIES
PRIMARY: OBSTETRICS AND GYNECOLOGY
SECONDARY: UNSPECIFIED
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: RESIDENT
HOSPITAL: UNIVERSITY HOSP SEATTLE WA 98195
DATES OF TRAINING: 07/87-06/90 -- (CONFIRMED)
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: INTERN
HOSPITAL: UNIVERSITY HOSP SEATTLE WA 98195
DATES OF TRAINING: 07/86-06/87 -- (CONFIRMED)
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED

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 1990 AMERICAN MEDICAL ASSOCIATION. SEE REVERSE.***AMA FILES CHECKED

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.

BOARD OF MEDICAL EXAMINERS

February 5, 1990

Mark Thomas Bowers, MD
2751 - 46th Ave SW
Seattle, WA 98116

Dear Dr. Bowers:

This is to notify you that your application to practice medicine in the State of Washington is incomplete. According to our records the following items are deficiency in your application file:

**AMA Profile**

Upon receipt of the above mentioned items, your application will be considered completed and will be forwarded to a Board member for review.

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

Sincerely,

Manet Wade, Program Representative
Board of Medical Examiners
P.O. Box 1099
Olympia, WA 98507-1099
(206) 753-2205

STATE OF WASHINGTON
DEPARTMENT OF LICENSING
Highways-Licenses Building • Olympia, Washington 98504 • (206) 753-6918
Mary Faulk, *Director*

**BOARD OF MEDICAL EXAMINERS**

November 21, 1989

Mark Thomas Bowers, MD
2751 - 46th Ave SW
Seattle, WA 98116

Dear Dr. Bowers:

This is to acknowledge receipt of your application to practice medicine in the State of Washington. According to our records the following items are lacking in your application file:

**AMA profile**
**AIDS education affidavit**

Upon receipt of the above mentioned items, your application will be considered completed and will be forwarded to a Board member for review.

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

Sincerely,

Manet Wade

Manet Wade, Program Representative
Board of Medical Examiners
P.O. Box 1099
Olympia, WA 98507-1099
(206) 753-2205

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

MEDICAL EXAMINER'S
DEC 14 1989
RCVD

RECEIVED
DEC 14 1989

## 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 Bowers (LAST) Mark (FIRST) Thomas (MIDDLE)

Date of Birth 1 / 18 / 1958 Social Security Number 2 - DOH Licensee Social Security Number - RCW 4...
TO ASSIST THE SCHOOL IN LOCATING YOUR RECORDS

Profession for which I am applying Full licensure

---

**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 Bowers (LAST) Mark (FIRST) Thomas (MIDDLE)

Dates of AIDS education and training 11/2/88 5/5 - 5/12 - 5/19 - 11/15 (1989)

Contact hours 5

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 Leon R. Spadoni, M.D.

Title Professor and Vice Chairman

SCHOOL SEAL

School/Program University of Washington Affiliated Hospitals

In State Of Washington

Date 12-11-89

MED 657-073 AIDS ED/TRAIN CERT/VER 7-8 (N/2/89) Page 3 of 3

Sent 12/11/89

STATE OF WASHINGTON

# DEPARTMENT OF LICENSING

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

## 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 Bowers (LAST) Mark (FIRST) Thomas (MIDDLE)

Street Address 2751 46th Avenue SW

City Seattle State WA ZIP 98116

Date of Birth 1 / 18 / 58

Profession for which I am now applying M.D. (Full licensure) / 08-64N

I certify that I have received 4 hours of AIDS education and training through University of Washington (ORGANIZATION, COLLEGE, UNIVERSITY, ETC.) on 5/5, 5/12, 5/19, 11/15 (1989) 11/2/88 (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.

M Bowers (SIGNATURE) 11/20/89 (DATE)

# TRANSCRIPT OF ACADEMIC RECORD
## University of Minnesota



| STUDENT NAME | BIRTHDATE | FILE NO | SOC SEC NO |
|---|---|---|---|
| BOWERS MARK THOMAS | 01/18/58 | 1194487 | 2 - DOH Licensee Social ... |

STUDENT ADDRESS
1474 SARGENT AVE. SO.
ST. PAUL MN 55105

CURRENT INFORMATION

| CAMPUS | COLLEGE | AREA |
|---|---|---|
| TWIN CITIES | MED SCH-TC | |

| MAJOR | SUBPROGRAM | DEGREE SOUGHT |
|---|---|---|
| MEDICINE | | MD |

TRANSCRIPT LEVEL PROFESSIONAL

UNIVERSITY OF MINNESOTA DEGREES GRANTED

MEDICAL SCHOOL
DOCTOR OF MEDICINE
GRANTED JUNE 14, 1986

FALL QUARTER 1982 MED SCH-TC
MAJOR MEDICINE

| | | | |
|---|---|---|---|
| ANAT 5100 | GROSS HUMAN ANATOMY | 10.0 | S |
| ANAT 5103 | HUMAN HISTOLOGY | 6.0 | S |
| ANAT 5106 | HUMAN EMBROYOLOGY | 4.0 | E |
| MDBC 5100 | MEDICAL BIOCHEMISTR | 5.0 | O |

COMPL CRS 25.0 QTR GPA 0.00 CUM GPA 0.00

WINTER QUARTER 1983 MED SCH-TC
MAJOR MEDICINE

| | | | |
|---|---|---|---|
| ANAT 5111 | HUMAN NEUROANATOMY | 3.0 | S |
| MDBC 5101 | MEDICAL BIOCHEM | 5.0 | S |
| MICB 5205 | MICB FOR MED STUDEN | 5.0 | O |
| PHSL 5110 | HUMAN PHYSIOLOGY | 5.0 | S |

COMPL CRS 18.0 QTR GPA 0.00 CUM GPA 0.00

SPRING QUARTER 1983 MED SCH-TC
MAJOR MEDICINE

| | | | |
|---|---|---|---|
| INMD 5115 | CLIN CORRELATIONS | 3.0 | S |
| LAMP 5101 | GENERAL PATHOLOGY | 2.0 | E |
| MICB 5206 | MICB FOR MED STUDEN | 5.0 | O |
| PHSL 5111 | HUMAN PHYSIOLOGY | 6.0 | E |

COMPL CRS 16.0 QTR GPA 0.00 CUM GPA 0.00

SUMMER SESSION I 1983 MED SCH-TC
MAJOR MEDICINE

| | | | |
|---|---|---|---|
| ADPY 5107 | HUMAN BEHAVIOR | 4.0 | O |
| INMD 5100 | CLIN MEDICINE I | 5.0 | S |
| INMD 5110 | HUMAN GENETICS | 2.0 | S |
| INMD 5233 | HUMAN SEXUALITY | 2.0 | S |
| LAMP 5101 | GENERAL PATHOLOGY | 4.0 | E |

COMPL CRS 17.0 QTR GPA 0.00 CUM GPA 0.00

FALL QUARTER 1983 MED SCH-TC
MAJOR MEDICINE

| | | | |
|---|---|---|---|
| INMD 5101 | CLIN MEDICINE II | 4.0 | S |
| INMD 5201 | PATHOPHYSIOLOGY I | 12.0 | E |
| LAMP 5102 | ORGAN SYSTEM PATH | 4.0 | S |
| PHCL 5110 | PHARMACOLOGY | 5.0 | S |

COMPL CRS 25.0 QTR GPA 0.00 CUM GPA 0.00

WINTER QUARTER 1984 MED SCH-TC
MAJOR MEDICINE

| | | | |
|---|---|---|---|
| INMD 5202 | PATHOPHYSIOLOGY II | 11.0 | O |
| INMD 5203 | PATHOPHYSIOLOGY III | 11.0 | S |
| LAMP 5102 | ORGAN SYSTEM PATH | 4.0 | S |
| PHCL 5111 | PHARMACOLOGY | 4.0 | S |

COMPL CRS 30.0 QTR GPA 0.00 CUM GPA 0.00

SPRING QUARTER 1984 MED SCH-TC
MAJOR MEDICINE

| | | | |
|---|---|---|---|
| INMD 5102 | CLIN MED INTERNAL M | 4.0 | S |
| INMD 5103 | CLIN MED FAM PRACT | 4.0 | E |
| INMD 5104 | CLIN MED PEDIATRICS | 4.0 | S |
| INMD 5105 | CLIN MED NEUROLOGY | 4.0 | E |
| INMD 5204 | PATHOPHYSIOLOGY IV | 6.0 | E |

COMPL CRS 22.0 QTR GPA 0.00 CUM GPA 0.00

SUMMER SESSION I 1984 MED SCH-TC
MAJOR MEDICINE

| | | | |
|---|---|---|---|
| SURG 5500 | EXTERNSHIP SURGERY | 9.0 | E |

COMPL CRS 9.0 QTR GPA 0.00 CUM GPA 0.00

FALL QUARTER 1984 MED SCH-TC
MAJOR MEDICINE MD
FREE TIME FALL 1984.

COMPL CRS 0.0 QTR GPA 0.00 CUM GPA 0.00

ISSUED TO: DIV. OF PROFESSIONAL LICENSING
LIMITED LICENSE SECTION
C/O DONNA HULL
P.O. BOX 9649
OLYMPIA, WA 98504

RECEIVED
SEP 16 1986
DIVISION OF PROFESSIONAL LICENSING

SEP 10 1986

UNIVERSITY OF MINNESOTA
OFFICE OF THE REGISTRAR

Samuel R. Lewis
DIRECTOR
REGISTRATION, STUDENT RECORDS, AND SCHEDULING OFFICE

The face of this document has a colored background on white paper. The back of this document contains the University watermark. Hold at an angle to view.

Official transcript only if registrar's signature, embossed University seal, and date are affixed. The Family Educational Rights and Privacy Act provides that this transcript is not to be released to any other person or agency without written consent of the student.

# Key to Transcript

## Release of Information

The Family Educational Rights and Privacy Act of 1974 as amended prohibits the release of this record or disclosure of its contents to any third party without the written consent of the student.

## Accreditation

The University of Minnesota is accredited by the North Central Association of Colleges and Secondary Schools, by the National Council for the Accreditation of Teacher Education, and by numerous other agencies.

## Authentication of the Transcript

This transcript is arranged differently because a new transcript system went into effect winter quarter 1986. This document is printed on blue safety paper. It is official if the regents' seal is embossed on the face of the transcript and the signature of the registrar appears in the right-hand corner in blue ink. The reverse side of the transcript contains water print seals of the University, which are visible by tilting the paper toward the light. If the transcript is copied, the word VOID will appear in shadow outline on the face. Use of ink eradicator or eraser will be evident and will eliminate the colored background.

## Academic Calendar

The University of Minnesota system operates on the quarter system on all campuses, with two exceptions. The Law School on the Twin Cities campus changed to semesters beginning in fall 1981; credits for the Law School are shown in semester units. Certain Continuing Education and Extension courses are taught on the semester basis; those credits are shown in quarter units.

## Honors

Effective spring 1985, the University policy on public information was amended to allow academic honors to be shown on the official transcript.

## Course Numbering System

| | |
|---|---|
| 0000 to 0998 | noncredit courses |
| 1000 to 1998 | introductory courses--primarily for freshmen and sophomores |
| 3000 to 3998 | intermediate courses--primarily for juniors and seniors but sometimes open to others with a C average overall and in prerequisites |
| 5000 to 5998 | advanced courses--open to juniors, seniors, and graduate students |
| 8000 to 8998 | graduate courses--open to graduate students and authorized students in professional schools and professional graduate programs |

## Credit

University credit -- All credits are in quarter units except for the Law School on the Twin Cities campus, which has had semester credits since fall 1981.

Transfer credit -- All work submitted for transfer from other colleges is shown in quarter units. Only unbracketed credit applies to the student's current degree program. Accepted credit will show as transfer credit on the transcript and is not reflected in the grade point average.

## Grade Point Average Formula

The grade point average is calculated using A = 4.0, B = 3.0, C = 2.0, and D = 1.0. In addition, there are campuses and colleges within the University system using numeric systems in which A– = 3.7, B+ = 3.3, B– = 2.7, C+ = 2.3, C– = 1.7, D+ = 1.3, and D– = 0.7. The grade point average is determined by dividing the number of grade points earned by the number of credits earned.

## Grading Definitions

A — Represents achievement that is outstanding relative to the level necessary to meet course requirements.

B — Represents achievement that is significantly above the level necessary to meet course requirements.

C — Represents achievement that meets the basic course requirements in every respect.

D — Represents achievement that is worthy of credit even though it does not fully meet the basic course requirements in every respect.

E — Represents achievement that is significantly greater than the level required to meet the basic course requirements but not judged to be outstanding.

F — Represents unsuccessful completion of work.

I — Assigned by an instructor to indicate an incomplete in accordance with provisions announced in class at the beginning of the quarter, when in the instructor's opinion there is a reasonable expectation that the student can successfully complete the work of the course. On the Twin Cities campus, an I that is not made up by the end of the student's next quarter in residence becomes an N; instructors may set dates within the quarter for make-up examinations. On the Crookston campus, an I changes to an F at the end of the sixth week of the student's next quarter in residence. On the Duluth campus, an I changes to an F or N if not made up by the end of the sixth week of the student's next quarter in residence. On the Morris campus, an I remains permanent until it is changed by the instructor. In the Graduate School, in master's degree programs in undergraduate colleges, and in the Doctor of Medicine programs, an I remains until it is changed by the instructor. When an I is changed to another symbol, the I is removed from the record.

N — Assigned when the student does not earn an S or D or higher and is not assigned an I. It stands for no credit.

O — Represents outstanding achievement (for Doctor of Medicine and Doctor of Veterinary Medicine programs).

P — An achievement symbol designating passing work.

Q — An achievement symbol designating passing work.

R — A course-related authorized registration symbol.

S — An achievement symbol designating satisfactory work.

V — Indicates registration as an auditor or visitor — a noncredit, nongrade registration.

W — Entered by the student records office when a student officially withdraws from a course in accordance with procedures set by the student's college or campus.

X — Reported to indicate that a student may continue in a sequence course in which a grade cannot be determined until the full sequence is completed. The instructor submits a grade for each X when the student has completed the sequence.

Duluth campus grading symbols include A (highest), A–, B+, B, B–, C+, C, C–, D+, D, E, F, O, N, P, and S.

The Morris campus grading system only included symbols of accomplishment on the official transcript before fall 1985.

On the Twin Cities campus from fall quarter 1972 through summer session 1977 and on the Morris campus from fall quarter 1972 through summer session 1985, the official University transcript included only positive academic achievements. Courses in which the student received a grade of N or a registration symbol of I or W did not appear on the transcript. Failure to meet minimum course standards was not recorded during this period. Beginning fall quarter 1977, the University of Minnesota returned to the pre-fall quarter 1972 policy under which the transcript lists all courses attempted and all grades or registration symbols received.

## Symbols Following Course Numbers

E (following course number) — On the Duluth campus, indicates registration in a Continuing Education and Extension course.

H (following course number) — Designates an honors course.

X (following course number) — Designates extra credit.

Y (following course number) — Designates independent study.

[ ] (surrounding credits or symbols) — Indicates that the course or registration does not apply in the student's current degree program.

## Campus Records Office Locations

**University of Minnesota Technical College, Crookston**
109 Selvig Hall
Crookston, MN 56716
(218) 281-6510, X346

**University of Minnesota, Duluth**
104 Darland Administration Building
Duluth, MN 55812
(218) 726-7500

**University of Minnesota, Morris**
212 Behmler Hall
Morris, MN 56267
(612) 589-2211, X6027

**University of Minnesota, Minneapolis**
155 Williamson Hall
Minneapolis, MN 55455
(612) 625-5333

**University of Minnesota, St. Paul**
130 Coffey Hall
St. Paul, MN 55108
(612) 624-3731

**University of Minnesota Technical College, Waseca**
Room C110 Administration Building
Waseca, MN 56093
(507) 835-1000, X242

# TRANSCRIPT OF ACADEMIC RECORD
University of Minnesota



STUDENT NAME: BOWERS MARK THOMAS
TRANSCRIPT LEVEL: PROFESSIONAL
BIRTHDATE: 01/18/58
FILE NO: 1194487
SOC SEC NO: 2 - DOH Licensee Socia...

WINTER QUARTER 1985 MED SCH-TC
MAJOR: MEDICINE MD

| | | | |
|---|---|---|---|
| OBST 5500 | EXTERNSHIP OBST | 9.0 | E |
| PED 5501 | PEDIATRIC CLERKSHIP | 9.0 | O |

COMPL CRS 18.0 QTR GPA 0.00 CUM GPA 0.00

SPRING QUARTER 1985 MED SCH-TC
MAJOR: MEDICINE MD

| | | | |
|---|---|---|---|
| MED 5500 | MED EXTERNSHIP I | 9.0 | S |
| NEUR 5510 | EXTERNSH CLIN PRACT | 9.0 | S |

COMPL CRS 18.0 QTR GPA 0.00 CUM GPA 0.00

SUMMER SESSION I 1985 MED SCH-TC
MAJOR: MEDICINE MD

| | | | |
|---|---|---|---|
| INMD 5555 | ELECTIVE AWAY-CREDIT | 4.5 | O |
| MED 5525 | CARDIOVASC DISEASE | 9.0 | E |

COMPL CRS 13.5 QTR GPA 0.00 CUM GPA 0.00

FALL QUARTER 1985 MED SCH-TC
MAJOR: MEDICINE MD

| | | | |
|---|---|---|---|
| MED 5501 | EXTERNSHIP IN MED | 9.0 | O |
| UROL 5180 | EXTERNSHIP UROLOGY | 4.5 | O |

COMPL CRS 13.5 QTR GPA 0.00 CUM GPA 0.00

WINTER QUARTER 1986 MED SCH-TC
MAJOR: MEDICINE MD

| | | | |
|---|---|---|---|
| INMD 5500 | DIDACTIC/SELECTIVE | 9.0 | E |
| LAMP 5187 | CLIN PATHOL EXTERN | 9.0 | E |

PAID M.D. GRADUATION FEE 03-03-86

COMPL CRS 18.0 QTR GPA 0.00 CUM GPA 0.00

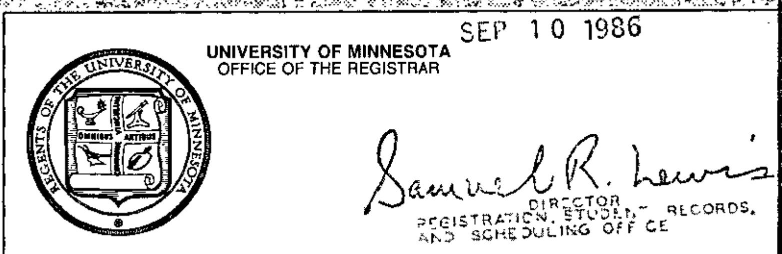
SPRING QUARTER 1986 MED SCH-TC
MAJOR: MEDICINE MD

| | | | |
|---|---|---|---|
| ADPY 5500 | PSYCHIATRY EXTERNSH | 9.0 | E |
| ANAT 5509 | THE ABDOMEN | 4.5 | E |
| ANAT 5510 | PERINEUM,GENITAL-UR | 4.5 | E |

COMPL CRS 18.0 QTR GPA 0.00 CUM GPA 0.00

UNIVERSITY OF MINNESOTA SUMMARY INFORMATION

| | | | |
|---|---|---|---|
| UM CREDITS | 261.0 | GPA CREDITS | .0 |
| TRANSFER CRS | .0 | GPA GRADE PTS | .0 |
| TOTAL CREDITS | 261.0 | UM CUM GPA | 0.00 |




The face of this document has a colored background on white paper. The back of this document contains the University watermark. Hold at an angle to view.

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(218) 281-6510, X346

**University of Minnesota, Duluth**
104 Darland Administration Building
Duluth, MN 55812
(218) 726-7500

**University of Minnesota, Morris**
212 Behmler Hall
Morris, MN 56267
(612) 589-2211, X6027

**University of Minnesota, Minneapolis**
155 Williamson Hall
Minneapolis, MN 55455
(612) 625-5333

**University of Minnesota, St. Paul**
130 Coffey Hall
St. Paul, MN 55108
(612) 624-3731

**University of Minnesota Technical College, Waseca**
Room C110 Administration Building
Waseca, MN 56093
(507) 835-1000, X242

RECEIVED
NOV 01 1989

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

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.

Mark Thomas Bowers
*Applicant (Please print or type)*

18 January 1958
*(Birthdate)*

Mark Thomas Bowers
*Signature of Applicant*

---

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

1. The above individual is or was engaged in post-graduate training in our program from June 25, 1986 *(Beginning Date)* TO June 30, 1990 *(Ending Date)*, In the field of Obstetrics and Gynecology.

2. Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evauations conducted.) Excellent performance as a resident in Ob-Gyn. Excellent data base + doctor-patient relationship. High moral + Ethical standards

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

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

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

Thank you.

NAME Leon R. Spadoni, M.D.
TITLE Professor and Vice Chairman
HOSPITAL University of Washington Medical Center *(Please type or print)*
ADDRESS Department of OB/GYN RH-20
Seattle, WA 98195
DATE October 24, 1989

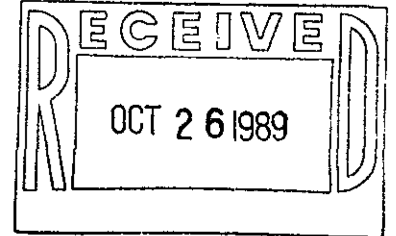
MED 657 034 POST GRADUATE TRAINING (8/10/87)

RECEIVED
OCT 31 1989

**TO THE APPLICANT**

Complete the identifying information below and submit to:

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




**Attention: Teresa Hubbard**
**Coordinator of Disciplinary Data Bank**

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

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

Date: Oct. 12, 1989

Dear Ms. Hubbard:

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

**NAME:** Mark T. Bowers, MD.

**SSN #:** 2 - DOH Licensee Social Security Number ...

**MEDICAL SCHOOL OF GRADUATION:** Univ. of Minnesota

**YEAR OF GRADUATION:** 1986

**BIRTHDATE:** 1-18-58

- - - - - - - - - - - - - - - - - - - - - - - - -

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

**RESPONSE:**

OCT 26 1989

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

MED 657-072 MEDICAL DISCIPLINARY REQUEST (1-2-87)

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

Mark Thomas Bowers, M.D.

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

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

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

Philadelphia, Pa.
07/01/87

Certificate # 326048

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 MINNESOTA MEDICAL SCH in JUNE 1986 and whose birth date is 01/18/1958. 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 06/84 | | |
| Anatomy | 555 | 84 |
| Physiology | 530 | 82 |
| Biochemistry | 615 | 88 |
| Pathology | 665 | 91 |
| Microbiology | 700 | 93 |
| Pharmacology | 580 | 86 |
| Behavioral Sciences | 620 | 88 |
| TOTAL TEST (Minimum Passing Score 380/75) | 630 | 88 |
| PART II passed 04/86 | | |
| Medicine | 575 | 86 |
| Surgery | 565 | 85 |
| Obstetrics and Gynecology | 605 | 87 |
| Public Health and Preventive Medicine | 625 | 88 |
| Pediatrics | 570 | 86 |
| Psychiatry | 550 | 85 |
| TOTAL TEST (Minimum Passing Score 290/75) | 600 | 86 |
| PART III passed 05/87 | | |
| A General Test of Clinical Competence | | |
| TOTAL TEST (Minimum Passing Score 290/75) | 505 | 82.3 |
| GENERAL AVERAGE (Parts, I, II, and III Scale Score) | | 85.4 |

*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.

Melanie Valente
Secretary for Certification

SEAL

11/01/89
Date

Application File_445706_pdf-r.pdf redacted on: 4/9/2018 07:54

Redaction Summary ( 13 redactions )

---

2 Privilege / Exemption reasons used:

1 -- "DOH Licensee Health Professional Home Address and/or Home Phone Number - RCW 42.56.350(2)" ( 4 instances )
2 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" ( 9 instances )

Redacted pages:

Page 2, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 3, DOH Licensee Health Professional Home Address and/or Home Phone Number - RCW 42.56.350(2), 2 instances
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