

✓-AW 2980 B 1003 UP 75.00

APPLICATION FOR  
18146  
(Check one)  
3-17-80

LICENSE TO PRACTICE.

- MEDICINE
- OSTEOPATHY AND SURGERY

MONEY CTL.

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

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

Make remittance payable to:  
STATE TREASURER

Note: If you have a Limited License to Practice then the fee with exam is \$100.00 and without exam is \$50.00

Application for licensure is made by: (Check one)

- National Board waiver.
- Reciprocity from (state) \_\_\_\_\_
- Examination. (FLEX)
- L. M. C. C.
- Flex waiver.

MC-IN-TR-C544RU      0 00-00-00  
 MCINTYRE, ROBERT CAMPBELL

FOR OFFICE USE ONLY									
PROG	TRANS	PROF CODE	PIC/CIC		EXPIRATION DATE	EXPT	STAT	TYPE	
LA		252							
KEY DATE	CLASS	ASSN	BILLED AMOUNT		SIGN	SPLIT	QTRD		

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME MCINTYRE ROBERT CAMPBELL  
Last First Middle

ADDRESS 859 South 11th East

CITY Salt Lake City STATE Utah ZIP 84102 COUNTY Salt Lake

TELEPHONE NO. 581 8633 SOCIAL SECURITY NUMBER 1 - DOH Licensee Social Security N...  
 Enter the number at which you can be reached during normal business hours. Requested for identification purposes only. Entering SSN is voluntary and is not required for licensing approval.

SEX (For M) M DATE OF BIRTH 12 31 46  
mo. day yr.

BIRTHPLACE Seattle WA King  
City State County

MEDICAL SPECIALTY Family Practice

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

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

INSTRUCTIONS

1. ALL APPLICANTS
  - (a) This application and supporting documents, should be filed with the Division of Professional Licensing at least forty-five (45) days prior to the board meeting at which it is to be reviewed. (Or for Flex exam by April 1 for the June examination and October 1 for the December examination.)
  - (b) If additional space is required, attach separate (8½ x 11 inch) sheets indicating the section to which they refer.
  - (c) COPIES OF ALL DOCUMENTS MUST BE CERTIFIED AS TRUE AND NOTARIZED.
  - (d) ALL APPLICATIONS MUST BE ACCOMPANIED BY APPLICABLE FEE. FEES ARE NON-REFUNDABLE.

LICENSING  
 DIVISION  
 11/1/80

**APPLICANTS MUST PROVIDE THE FOLLOWING:**

**2. MEDICINE ONLY**

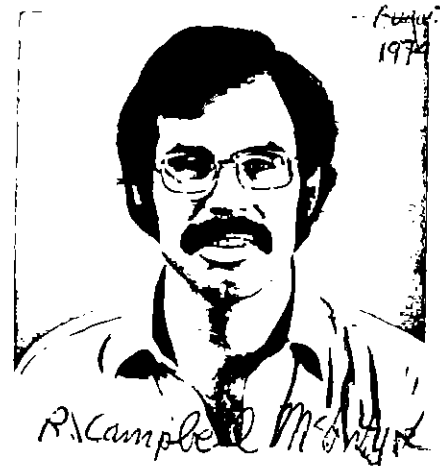
- (a) Copy of diploma issued by a medical school approved by the Board of Medical Examiners.
- (b) Certificate showing completion of one year of postgraduate medical training in a program acceptable to the Board.
- (c) Foreign medical graduates must submit proof of medical school curriculum meeting the requirements of the Washington Medical Practice Act, RCW 18.71.055.
- (d) Foreign medical graduates must provide their **original** standard E.C.F.M.G. certificate.
- (e) Two (2) letters of recommendation attached to this application.
- (f) See accompanying EXCERPTS for more detailed information.

**3. OSTEOPATHY AND SURGERY ONLY**

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

**IDENTIFICATION**

HEIGHT 6' 2"	WEIGHT 190 lbs.
COLOR OF EYES Brown	COLOR OF HAIR Black



**PERSONAL DATA**

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

- |   | Yes                      | No                                  |
|---|--------------------------|-------------------------------------|
| 1. Have you ever been called before any state board for interrogation concerning any violation of the laws or rules pertaining to the profession for which you are applying or unethical conduct? ..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have you ever been convicted of a felony or misdemeanor other than traffic violations? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you ever been convicted of a violation of the Controlled Substances Act, or any narcotic law? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you ever had a license to practice revoked or suspended? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you ever been addicted to or treated for addiction to narcotic drugs? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you ever received psychiatric treatment or received treatment for a mental illness? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Have you ever been denied the right to take an examination for licensing in any state? .....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

# PREVIOUS REGISTRATION

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

State or Other	Profession	Certificate		Permanent or Temporary	License Received By		Currently in Force
		Year	No.		Examination	Other	
Utah	M.D.	1975	5225	Temp.		National Board waiver	Yes
Tennessee	M.D.	1977	10384	Temp.		National Board waiver	No
Trust Territory of the Pacific Islands	M.D.	1978	288	Temp.		"	Yes
National Board of Med. Examiners	M.D.	1975	138495	Permanent	Yes		

# PROFESSIONAL TRAINING AND EXPERIENCE

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

From Month, Day, Year	To 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
9/65	6/69	Washington State U., Pullman WA	B.S. - Biochemistry
9/69	12/69	U. of Washington, Seattle WA	Grad. Student - Organic Chem.
9/70	6/74	George Washington U., Washington D.C.	M.D.
7/1/74	4/30/76	U. of Utah Medical Center, SLC, Utah	Family Practice Resident
7/1/76	6/30/79	Center for Disease Control, Atlanta, GA	Epidemiologist in the USPHS
7/15/79	9/22/79*	Southeast Asia Regional Office - WHO, New Delhi, India	Consultant Epidemiologist
8/1/79	Present	U. of Utah Med. Center, SLC, Utah	3rd yr. of F.P. Residency
* Two months of this experience counted as credit for my 3rd year of Family Practice Residency.			

**CERTIFICATION**

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

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

Applicants for licensure by STATE RECIPROcity or L.M.C.C. must provide the following certification:  
To be executed by the Secretary of the Board or Department of the State upon whose license the applicant relies for reciprocal registration in Washington.

I certify that the aforesaid ..... in h..... examination before the

of this state attained a general average of ..... percent (or FLEX WEIGHTED AVERAGE OF ..... percent) and the following marks in the subjects named:

Subject	Percent	Subject	Percent

If FLEX examination please provide the following averages for each day.

DAY I ..... DAY II ..... DAY III .....  
BASIC SCIENCES ..... CLINICAL SCIENCES ..... CLINICAL COMPETENCE .....

I do further certify that a certificate to practice .....

was issued to said applicant on the ..... day of ....., 19....., upon the following qualifications:

..... and said certificate has not been revoked or suspended and that, from the records now on file in this office, I believe h..... to be of good moral character and worthy of professional recognition, and recommend h..... to the Division of Professional Licensing of the State of Washington as a fit and proper person to receive recognition as an applicant for a reciprocity certificate permitting h..... to practice .....

In testimony thereof, witness my hand and seal this ..... day of ....., 19.....

[SEAL]

SECRETARY OF THE .....  
POST OFFICE ADDRESS .....

**AFFIDAVIT**

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

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

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

R. Campbell McIntyre  
applicant's signature

Subscribed and sworn to before me this 22nd day of January, 1980

[SEAL]

Deanne A. Lynch  
Notary Public for the state of Utah  
Palms Lake City, Utah

MEDICAL BOARD WORKSHEET

NAME Robert Campbell McIntyre DATE OF RECEIPT 1/29/80

1. LICENSURE BY d.o.b. 12/31/46

- a) National Board Waiver
- b) Reciprocity from \_\_\_\_\_
- c) FLEX Waiver
- d) LMCC
- e) Examination

2. FEE

3. ADDITIONAL PHOTOGRAPH

4. PROOF OF EDUCATIONAL EXPERIENCE

- a) Medical School Diploma
- b) Postgraduate Medical Training
- c) Chronology
- d) Personal Qualifications

5. FOREIGN GRADUATE

- a) ECFMG
- b) Medical School Subjects

6. LETTERS OF RECOMMENDATION

7. AFFIDAVIT

8. STATE CLEARANCE Mid. 1-30-80

9. AMA CLEARANCE Mid. 1-30-80

ADMINISTRATIVE RECOMMENDATION complete

BOARD ACTION

	LICENSE	EXAM
APPROVED	<input checked="" type="checkbox"/>	<input type="checkbox"/>
DISAPPROVED	<input type="checkbox"/>	<input type="checkbox"/>

DATE Mar 4 '80

PENDING \_\_\_\_\_

REVIEWED BY John H. Walker MD

March 20, 1980

Robert C. McIntyre, M.D.  
859 S. 11th East  
Salt Lake City, UT 84102

Dear Dr. McIntyre:

We are pleased to advise that you have been issued Washington State Physician and Surgeon certification No. 18146 dated March 17, 1980. Enclosed you will find your wallet size license which bears your certificate number and certificate date. Your medical certificate will be forwarded to you as soon as it is engraved. This necessitates some delay and you will not receive the certificate for several weeks.

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

Sincerely

JOAN BAIRD  
ADMINISTRATOR

Mrs. Joanne Redmond  
Assistant Administrator  
Medical/Nursing Services  
(206) 753-2205

JR/cmm

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION  
535 NORTH DEARBORN STREET  
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES  
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 02-06-80  
TIME: 11:57 AM

NAME: MC INTYRE, ROBT CAMPBELL, M.D. ✓

ADDRESS: UNIV MED CTR-FAM PRAC

SALT LAKE CITY UT

BIRTHPLACE: SEATTLE, WA

BIRTHDATE: 12/31/46 ✓

84112

MEDICAL EDUCATION (SCHOOL YEAR):

GEORGE WASHINGTON UNIV SCH MED, WASHINGTON DC 20037 ✓

✓ 1974

NATIONAL BOARD CERTIFICATION: 1975

LICENSES:

UT 1975 ✓

TN 1977 ✓

PHYSICIAN'S PROFESSIONAL ACTIVITIES:

RESIDENT

PRIMARY SPECIALTY: FAMILY PRACTICE

SECONDARY SPECIALTY: UNSPECIFIED

TERTIARY SPECIALTY: UNSPECIFIED

SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

MEMBER OF AMA: NOT MEMBER

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

CURRENT MEDICAL TRAINING: RESIDENT

HOSPITAL: UNIV UTAH AFFIL HOSPS ✓

SALT LAKE CTY UT 84112

DATES OF TRAINING: 07/79-06/80

SPECIALTY: FAMILY PRACTICE

SPECIALTY: UNSPECIFIED

INTERNSHIP:

NONE REPORTED TO DATE

RESIDENCY:

HOSPITAL: UNIV UTAH AFFIL HOSPS ✓

SALT LAKE CTY UT 84112

DATES OF TRAINING: 06/74-06/76

SPECIALTY: FAMILY PRACTICE

SPECIALTY: UNSPECIFIED

COPYRIGHT 1979 AMERICAN MEDICAL ASSOCIATION \*\*AMA FILES CHECKED\*\* SEE REVERSE

AMA PHYSICIAN PROFILE (CONTINUED)

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





STATE OF WASHINGTON

Dixy Lee Ray  
Governor

DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

RECEIVED  
FEB 1 1980

January 30, 1980

Dept. of Business Regulation  
Dept. of Registration  
330 East Fourth South St.  
Salt Lake City, UT 84111

DEPARTMENT OF  
REGISTRATION

Dear Sir:

The following medical doctor has made application for license to practice Medicine and Surgery in the State of Washington:

Robert Campbell McIntyre, M.D. (#5225) d.o.b. 12/31/46

The doctor advises that he is licensed to practice his profession in your state. To assist us in evaluating his application, we would appreciate receiving the following information.

	Yes	No
Licensed	<input checked="" type="checkbox"/>	<input type="checkbox"/>
License Permanent	<input checked="" type="checkbox"/>	<input type="checkbox"/>
License current	<input checked="" type="checkbox"/>	<input type="checkbox"/>
License invalid	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Reason: \_\_\_\_\_

Pertinent information, if any: \_\_\_\_\_

  
 \_\_\_\_\_  
 Signature  
 DIRECTOR, DEPARTMENT OF REGISTRATION  
 \_\_\_\_\_  
 Title

Sincerely,

JOAN BAIRD  
ADMINISTRATOR

State Board

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS OF THE UNITED STATES OF AMERICA		<div style="font-size: 2em; font-weight: bold; text-align: center;">RECEIVED</div> <div style="text-align: center;">                     FEB 1 1980                      DIVISION OF                      PROFESSIONAL LICENSING                 </div>
<b>ROBERT CAMPBELL MCINTYRE, M.D.</b>		
having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.		
Attest: <b>JOHN S. MILLIS</b> Chairman of the Board		
Philadelphia, Pa. <b>07/01/75</b>	SEAL Cert. # <b>138495</b>	<b>ROBERT A. CHASE</b> President of the Board

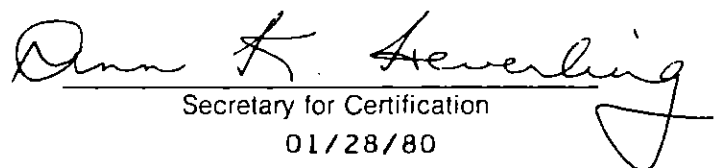
It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of **GEO WASHINGTON SCH OF MED** in **MAY 1974**, whose birth date is **12/31/1946**, following successful completion of all examinations required for Certification by the National Board of Medical Examiners.

The grades obtained are as follows:

	Standard* Score	Scale Score
<u>PART I passed 06/72</u>		
Anatomy, incl. histology and embryology	535	83
Physiology	615	88
Biochemistry	575	85
Pathology	495	80
Microbiology, incl. immunology	570	85
Pharmacology and Materia Medica	570	85
Behavioral Sciences		
<u>(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**</u>	565	84
<u>Part II passed 04/73</u>		
•Internal medicine and the medical specialties	410	77
Surgery and the surgical specialties	365	75
Obstetrics and Gynecology	500	82
Public Health and Preventive Medicine	525	83
Pediatrics	420	78
Psychiatry	530	84
<u>(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**</u>	445	80
<u>PART III passed 03/75</u>		
A General Test of Clinical Competence		
<u>(Minimum Passing Grade 290/75)</u>	AVERAGE	565
<u>GENERAL AVERAGE (Parts I, II, and III)</u>		82.8 (Scale Score)

\*Examinations taken since June 1971 are reported with both Standard and Scale Score Equivalents.

\*\*Since 1966 National Board criteria for certification are based upon candidate's Total Grade in Part I, Part II, and Part III, and not scores of individual subjects within each Part.

  
 Secretary for Certification  
 01/28/80

SEAL

# The George Washington University

in virtue of authority granted by

## The United States of America

has conferred upon

### Robert Campbell McIntyre

the Degree of

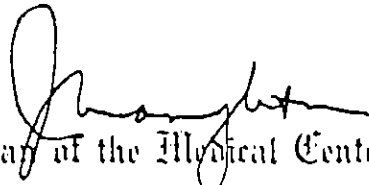
### Doctor of Medicine

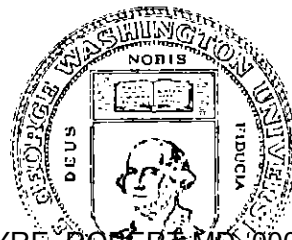
together with all the Honors, Rights and Privileges belonging to that Degree.


In Witness Whereof, this Diploma is granted bearing the seal of the University

Given at Washington in the District of Columbia this twenty-sixth day

of May, in the year of our Lord nineteen hundred and seventy-four.

  
Dean of the Medical Center



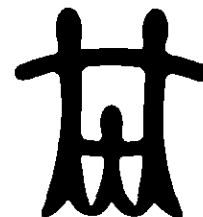
  
President of the University

THE UNIVERSITY OF UTAH COLLEGE OF MEDICINE  
AND  
AFFILIATED HOSPITALS FOR FAMILY PRACTICE



HEREBY MAKE KNOWN THAT

**Robert C. McIntyre, M.D.**



HAS SERVED SATISFACTORILY

AS A RESIDENT IN TRAINING IN FAMILY PRACTICE

FROM **June 24, 1974** TO **June 30, 1976**

IN WITNESS WHEREOF THIS CERTIFICATE IS AWARDED

David N. Sundwall M.D.

PROGRAM DIRECTOR

Robert S. Sorenson  
HOSPITAL ADMINISTRATOR

C. Hilmon Castle

DEPARTMENT CHAIRMAN

Bedwin I. Gorman  
DEAN

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING  
STATE OF WASHINGTON

This is to certify that I have known CAMPBELL Mc Intyre  
for 3 1/2 years, from 6/76 to present (7/80)  
during which period he was engaged in the study or active practice of medicine.  
To the best of my knowledge he is of good moral and professional character, is  
free from habits which might interfere with his professional activities and is  
worthy of holding a license to practice MEDICINE in the  
State of Washington.

PLEASE PRINT OR TYPE

Name DAVID S. FOLLAND, M.D.

Title Physician

Capacity in which applicant known Epidemiology officer, Tennessee,  
Physician in Practice, Utah

Address 880 E. 9000 St, SANDY, UTAH 84070

Licensed under laws of Utah

To practice MEDICINE

Remarks \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

David S. Folland MD

Signature

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING  
STATE OF WASHINGTON

This is to certify that I have known R. Campbell McIntyre  
for 5 1/2 years years, from July 74 to present (Jan 80)  
during which period he was engaged in the study or active practice of medicine.  
To the best of my knowledge he is of good moral and professional character, is  
free from habits which might interfere with his professional activities and is  
worthy of holding a license to practice medicine in the  
State of Washington.

PLEASE PRINT OR TYPE

Name JOHN A. GEZON  
Title M.D.

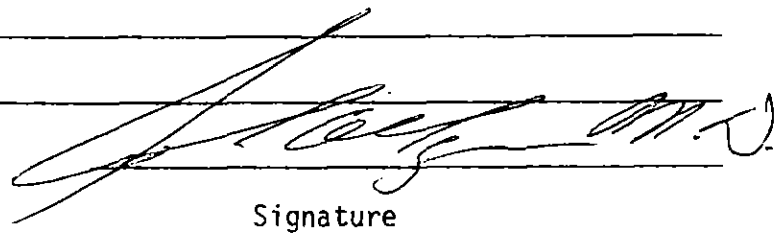
Capacity in which applicant known I was full time practitioner  
of Emergency Medicine at Holy Cross Hospital. Dr  
McIntyre was a family practice resident

Address 1045 E 1st South Salt Lake City, Utah 84112

Licensed under laws of UTAH

To practice Medicine

Remarks Outstanding physician. Dr McIntyre  
will be a real asset to the  
state of Washington

  
Signature

January 30, 1980

Robert Campbell McIntyre, M.D.  
859 South 11th East  
Salt Lake City, UT 84102

Dear Dr. McIntyre:

January 29, 1980

Thank you for your medical application received in this office March 14-15, 1980.  
The next meeting of the Board will be held on \_\_\_\_\_  
at which time your application will be reviewed, if complete. You will be advised of board decision  
approximately 2 weeks after the board meeting.

\*\*

Application appears complete ( )

Lacks the following ( )

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

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

Copies of all documents must be certified as true.

Applications not complete prior to board meeting date indicated above, will be placed in our inactive  
file.

**\*\*As of this date we have not received your National Board**

Remarks: "Certification of Record" showing subjects and grades.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sincerely,

By \_\_\_\_\_

Healing Arts Section

MED-657-14 App. Rec'd Ltr.

(R/9/75)

Redaction Summary ( 1 redaction )

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1 Privilege / Exemption reason used:

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

8

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