DATE	TELEPHONE LOG	INITIALS

Medical Quality Assurance Commission

Physician Application Worksheet

Pending Number ______
License Number ______

Name Melville, Jennifer L. Date of Birth 5-2-69

Date Received 6-18-97 Date Completed 7/22 Signature [signature]

✓ Fee	✓ Photo	✓ Personal Data	✓ AIDS	✓ Affidavit	L Archive File

Chronology ✓ Complete

Missing: ____ to ____ / ____ to ____ / ____ to ____

☐ Temporary Permit Requested ______ Status

FSMB	AMA	ECFMG	Reinstatement
7/7	7/21		

Personal Data Questions | Documentation Received

Malpractice Cases	Synopsis	Original Complaint	Disposition
1			
2			
3			
4			

Medical School ☐ U.S. ☐ Canadian ☐ International

Name U of CA Year of Degree 1995 ☒ Transcripts ☐ Translations

Examination Type ☐ National Boards ☐ FLEX ☐ USMLE ☐ State Exam ☐ LMCC 6/30 Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Graduate Training Programs	Accrediation Verified
6/19	U of WA	6/95-Present			

Received	State Licensure	Received	Hospital Privileges

Approved [signature: Susan Anthony] Date 7-25-97

Signature

Comments:

180

PHYSICIAN & SURGEON

REVENUE SECTION

PRINT NAME Melville, Jennifer

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236

[illegible]862 05/18/97 10000

Washington State Department of Health
Health Professional Quality Assurance Division
PO Box 1099
Olympia WA 98507-1099
(360) 753-2844
(360) 664-8689

RECEIVED
JUN 18 1997

APPLICATION FOR LICENSE TO PRACTICE MEDICINE
APPLICABLE FOR MD'S ONLY

All applications must be accompanied by applicable fee (fees are non-refundable).

All applicants carefully follow all instructions in general instructions.

It is the responsibility of the applicant to submit or request to have submitted, all required supporting documents.

Licensure Examination Taken (check one): ☐ National Board ☐ ____________ State Examination ☐ LMCC (must have been obtained after 1969)
☐ FLEX Examination ☒ USMLE Examination

For Office Use Only		
Certificate No. 35251	Issue Date 7-25-97	Expiration Date 5-2-98

Please Type or Print Clearly

Applicant's Name: MELVILLE (LAST) JENNIFER (FIRST) L (MIDDLE INITIAL)

Mailing Address: 2101 2ND AVENUE NORTH

City: SEATTLE State: WA Zip: 98109 County: KING

Telephone: (206) 216-0381
ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS

Social Security Number: 1 - DOH Licensee Social Security Number - ...
REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND NOT REQUIRED FOR LICENSING APPROVAL

Home Address: 2101 2ND AVENUE NORTH (STREET) SEATTE (CITY) WA (STATE) 98109 (ZIP)

Sex (F or M): F Birthdate: 05 (MONTH) 02 (DAY) 69 (YEAR) Birthplace: PITTSBURGH (CITY) PA (STATE) ALLEGHENY (COUNTY)

Medical Speciality: OBSTETRICS & GYNECOLOGY

Medical School: UNIVERSITY OF CALIFORNIA, LOS ANGELES (NAME) Year of Graduation: 1995

Have you previously applied for a Washington State License or limited license? ☒ Yes ☐ No

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

PERSONAL DATA

	Yes	No
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒

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

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

	Yes	No
2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒

"Currently" means recently enough so that the use of drugs may have an ongoing impact in one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

	Yes	No
3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☒
4. Are you currently engaged in the illegal use of controlled substances?	☐	☒

"Currently" means recently enough so that the use of drugs may have an ongoing impact in one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

	Yes	No
5. Have you ever been convicted, entered a plea of guilty, nolo contendere, or a plea of similar effect, or had prosecution or sentence deferred or suspended in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☒
b. a charge of a sex offense?	☐	☒
c. any other crime, other than minor traffic infractions? (Include driving under the influence and reckless driving.)	☐	☒
6. Have you ever been found in any civil, administrative, or criminal proceeding to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances of legend drugs, violated any drug laws, or prescribed controlled substances for yourself?	☐	☒
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☒
c. violated any state or federal law or rule regulating the practice of a health care profession?	☐	☒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgements, decisions, and agreements.	☐	☒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked suspended, or restricted by a state, federal, or foreign authority or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☒
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☒

PERSONAL DATA QUESTIONS (Continued)

		Yes	No
10.	Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☒
11.	Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☒
12.	To the best of your knowledge, are you the subject of an investigation by any licensing board as of the date of this application?	☐	☒
13.	Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☒

Identification	
HEIGHT 5'7"	WEIGHT 135#
COLOR OF EYES BLUE	COLOR OF HAIR BLONDE

In

1. C
2. N
3, T
4. Ir

MMelville 7/96

EDUCATION AND EXPERIENCE

Provide a chronological listing of your educational preparation and post-graduate training. (attach additional 8 1/2 X 11 sheets 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	Dates Attended From (mo/yr)	Dates Attended To (mo/yr)	Diploma or Degree Obtained (Quote titles in original language and translate to English.)
Medical Education (List all Medical Schools Attended) UNIV OF CALIFORNIA, LOS ANGELES	4	8/91	5/95	M.D. (06/02/95)
Post-Graduate Training (List all Programs Attended) UNIV OF WASHINGTON, OB-GYN	2	6/95	PRESENT	

PROFESSIONAL EXPERIENCE

In chronological order list all professional experience received since graduation from medical school to the present. (Exclude activities listed under other sections. Identify any periods of time break of 30 days or more.) (Attach additional 8 1/2 X 11 inch sheets if necessary.)

Nature of Experience or Practice	Dates of Experience From (mo/yr)	Dates of Experience To (mo/yr)
RESIDENCY IN OB-GYN, UNIV OF WASHINGTON MED CTR	6/95	PRESENT

HOSPITAL PRIVILEGES

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. (Attach additional 8 1/2 X 11 inch sheets if necessary.)

Name of Hospital (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	Dates	
	Beginning (mo/yr)	Ending (mo/yr)
N/A		

LICENSES IN OTHER STATES

List all licenses to practice medicine in any state, Canadian province or other country. (Include whether active or inactive.)

State, County or Province	Date License Issued	License Number	Basis of Licensure		Status of License Active or Inactive	Any Limitations on License
			Examination (Date Passed)	Endorsement		
N/A						

FIFTH PATHWAY (Foreign Trained Applicants only) (attach additional 8 1/2 X 11 inch sheets if necessary.)

Name and Location of Medical School	Name and Location of Hospital	Dates Attended	
		Beginning (mo/yr)	Ending (mo/yr)
N/A			

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 of Health if requested. (WAC 246-919-380)

[signature] APPLICANT'S SIGNATURE

6/10/97 DATE

APPLICANT'S ATTESTATION

I, JENNIFER L. MELVILLE, certify that I am the person described and identified in this 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 the 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 Commission any information, files or records required by the Commission for its evaluation of my professional, ethical and physical qualifications for licensure in the State of Washington. I understand the Commission may request a physical and mental evaluation to determine my fitness for practice.

APPLICANT'S SIGNATURE	DATE
[signature]	6/10/97

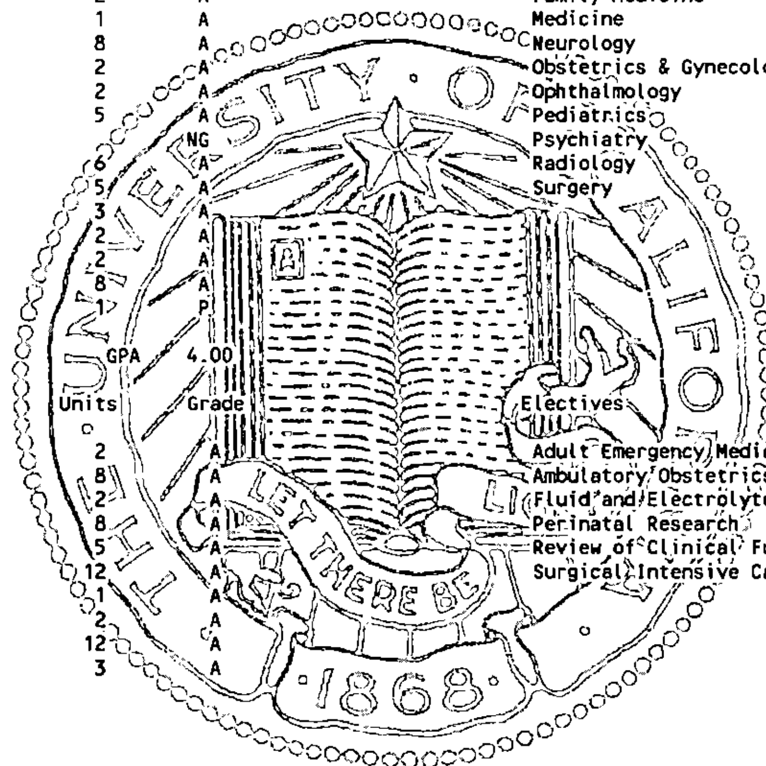
UNIVERSITY OF CALIFORNIA, LOS ANGELES

School of Medicine

Transcript for : Melville, Jennifer Lynn
Program - Class: UCLA - 1995

SSN : 1 - DOH Licens...
Alpha Omega Alpha

Date of M.D. Degree: 06/02/95
Matriculation Date: 08/12/91



FIRST YEAR: 1991-1992	Sem.	Units	Grade
Behavioral Sciences	F	5	A
Biomathematics	F	2	A
Biomedical Ethics	F	1	A
Gross Anatomy	F	8	A
Interactive Teaching 1	F	2	A
Interactive Teaching 2	F	2	A
Microscopic Anatomy	F	5	A
Clinical Correlates	F,S		NG
Basic Neurology	S	6	A
Biochemistry	S	5	A
Biochemistry Lab	S	3	A
Interactive Teaching 3	S	2	A
Interactive Teaching 4	S	2	A
Physiology	S	8	A
Social Medicine	S	1	P
		GPA	4.00

SECOND YEAR: 1992-1993	Sem.	Units	Grade
Epidemiology	F	2	A
General Pathology	F	8	A
Interactive Teaching	F	2	A
Microbiology & Immunology	F	8	A
Pharmacology	F	5	A
Clinical Fundamentals	S	12	A
Clinical Pharmacology	S	1	A
Genetics	S	2	A
Pathophysiology of Disease	S	12	A
Psychopathology	S	3	A
		GPA	4.00

THIRD AND FOURTH YEAR CONTINUUM: 1993-1995

Core Clinical Courses	Units(wks)	Grade
Dermatology	2 (1)	P
Family Medicine	8 (4)	A
Medicine	24 (12)	A
Neurology	4 (2)	P
Obstetrics & Gynecology	12 (6)	A
Ophthalmology	2 (1)	P
Pediatrics	12 (6)	A
Psychiatry	12 (6)	A
Radiology	4 (2)	P
Surgery	24 (12)	A
GPA		4.00

Electives	Location	Units(wks)	Grade
Adult Emergency Medicine	HARBOR	8 (4)	A
Ambulatory Obstetrics & Gynecology	OVH	8 (4)	A
Fluid and Electrolyte Balance	CHS	4 (2)	A
Perinatal Research	CHS	12 (6)	A
Review of Clinical Fundamentals	WVA	4 (2)	A
Surgical Intensive Care Unit	HARBOR	8 (4)	A
		GPA	4.00

RECEIVED NOV 27 1995 HPS

Memoranda:

This transcript is not valid unless this line is green.

This Transcript is not valid unless seal of school is impressed.

DEAN: [signature]

Date Printed: 11/20/95

UCLA School of Medicine
Office of Student Affairs
12-109 Center for the Health Sciences
Los Angeles, California 90024-1720

This document is official if it bears the UCLA School of Medicine seal and has two green lines on the face of the document.

Explanation of Program Grading

UCLA School of Medicine Program: Letter grades

Drew/UCLA Undergraduate Medical Education Program: Letter grades

UCR/UCLA Biomedical Sciences Program:

Letter grades *including* plus/minus for the first two years (basic sciences component of the curriculum)

Letter grades *only* for the final two years (clinical component of the curriculum)

Record Key

Ex	Exempt
I	Incomplete
IP	In Progress
NG	Nongraded
P/NP	Pass/Not Pass
Sub	Requirement fulfilled by substitution

Hospital Location Key

CHS	Center for the Health Sciences (UCLA)
CS	Cedars-Sinai Medical Center
HARBOR	Harbor-UCLA Medical Center
KDMC	King Drew Medical Center
OVH	Olive View Hospital
STM	St. Mary Medical Center, Long Beach
SVA	Sepulveda Veterans Administration Hospital
WVA	Wadsworth Veterans Administration Hospital

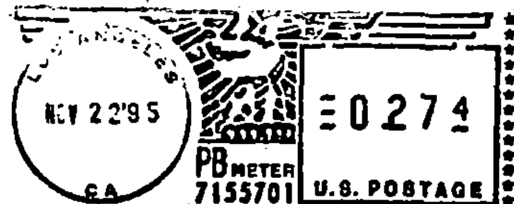
In compliance with the Family Education Rights and Privacy Act of 1974, this information is released on the condition that the recipient "will not permit any other party to have access to such information without the written consent of the student."

Official Transcript Enclosed

UNIVERSITY OF CALIFORNIA, LOS ANGELES
UCLA SCHOOL OF MEDICINE MC 88
STUDENT AFFAIRS
OFFICE OF THE DEAN
CENTER FOR THE HEALTH SCIENCES
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90095-1720

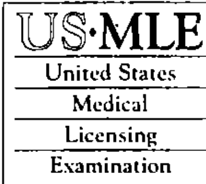
DROP SHIPMENT
AUTHORIZATION 1042
MAILED AT VAN NUYS, CA

PRESORT
FIRST CLASS



State of Washington
Department of Health
Health Professionals Section 5
1300 SE Quince Street
MS 47866
Olympia, WA 98504-7866

Official Transcript Enclosed



United States Medical Licensing Examination™
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 06/27/1997

Washington Medical Quality Assurance Commission
ATTN: Keith O Shafer, Exec Director
PO Box 47866
OLYMPIA, WA 98504-7866

Examinee: Melville, Jennifer Lynn
USMLE ID#: 4-022-961-9
DOB: 05 / 02 / 1969
Alt Name(s):

STEP1 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
6 /1993	PASS	229	176	90	75	

STEP2 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
8 /1994	PASS	226	167	87	75	

STEP3 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
WASHINGTON	5 /1996	PASS	213	176	85	75	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

See reverse side for explanation of information reported above.

Authenticity of USMLE™ Transcripts
Original, certified transcripts of United States Medical Licensing Examination (USMLE) scores are printed on blue safety paper and are produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The embossed USMLE seal in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history, and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For recent administrations, the mean and standard deviation of scores on the three-digit scale for first-time examinees from medical schools in the United States are approximately 205 and 20, respectively, and most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 82 on the two-digit scale is equivalent to a score of 200 on the three-digit scale. A score of 75 on the two-digit scale is always the minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each Step of USMLE is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 6 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

NOTATION REGARDING FSMB BOARD ACTION DATA BANK

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

ANNOTATIONS APPEARING UNDER "COMMENTS"

Special circumstances in connection with the administration of an examination may result in one of the following annotations being listed next to the score for that examination:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

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

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* To obtain information regarding the nature of the irregular behavior, the full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

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

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

Health

MD

TO: **Post-Graduate Training Program Director**

UNIV OF WASHINGTON MED CTR
FACILITY NAME

ADDRESS

PROCESSED
JUN 19 1997
HEALTH PROFESSIONS
SECTION 5

RE: Verification/Evaluation of Training

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

JENNIFER L. MELVILLE
APPLICANT (PRINT OR TYPE)

5/02/69
BIRTHDATE

[signature]
SIGNATURE OF APPLICANT

1. Dr. Jennifer Melville is or was engaged in post-graduate training in our program from July 1, 1995 (BEGINNING DATE (MONTH & YEAR)) to June 30, 1997 (ENDING DATE (MONTH & YEAR)).
   in the field of obstetrics and gynecology

2. **Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evaluations conducted.)** excellent clinical skills; superb clinical judgement; excellent interpersonal skills; outstanding knowledge base; caring and sensitive to needs of patients;

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.

Return to:
Medical Quality Assurance Commission
1300 SE Quince Street
P O Box 47866
Olympia, WA 98504-7866
(360) 664-8689 or (360) 753-2844

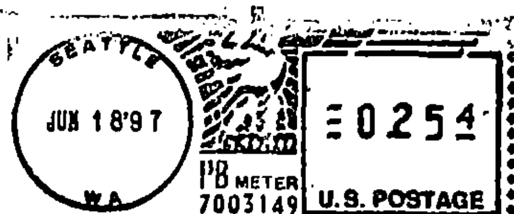
(Seal)

Signature Steven J Fabbe
Title Professor & Chair
Hospital University of Washington Medical Center
PLEASE TYPE OR PRINT
Address Dept of Ob/Gyn, Box 356460
Seattle, WA 98195
Date 6/17/97
Telephone (206) 616-8305

DOH 657-034 (Rev. 2/96)

Steven G. Gabbe, M.D.
Department of Obstetrics and Gynecology
Box 356460
Seattle, WA 98195-6460

PRESORTED
FIRST CLASS



63-5502

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

AUTO

UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

telnet (WA-RS6000-1)

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                        AAAAAAAA  SSS    SSS       III
MEDICAL BOARD                 ASSESSMENT SYSTEMS, INC.                 07-25-97
hab0303                             REAL SYSTEM          V2.5.14       03:16:00 PM
INDIVIDUAL NAME                          (JR,SR,III)      REFERENCE # ML20004996
   LAST MELVILLE                                          SOC SEC NUM     -  -
  FIRST JENNIFER                        lqADDITIONAL INFORMATIONqqqqqqqqqqqqqqqqk
 MIDDLE L                               x          SEX M =      MARRIED Y =     x
                                        x                                       x
RESIDENCE INFORMATION                   x   OTHER NAME                          x
UNIVERSITY OF WASHINGTON                xCORP. OFFICER                        = x
DEPT OF OB/GYN BOX 356460               xTRUST ACCOUNT                          x
SEATTLE, WA 98195-6460                  x                                       x
                                        x  BIRTH PLACE PITTSBURG PENN           x
                                        x         DATE 05-02-1969               x
PHONE: (   )    -     COUNTY:   17      x                                       x
       (   )    -     LGL ST:           xSCHOOL CODE 005.14                     x
                                        x   CE UNITS     0.00 REQD BY   -  -    x
NOTES                                   mqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqj

lqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqk
xCURRENT STATUS: A    EXPIRATION DATE: 07-31-1997  FIRST ISSUE DATE: 06-26-1995x
xRENEWAL STATUS: M   LAST ACTIVE DATE:   -  -     LAST RENEWAL DATE: 08-30-1996x
xCOMPLAINTS O/C:  0/ 0      AUTHORITY:                                          x
mqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqqj
1GO BACK  2NAM&ADDR 3EDUCATE  4LIC FUNC 5INVESTG  6         7OTHR DAT 8EXTD NOT
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PROCESSED
JUL 07 1997
HEALTH PROFESSIONS SECTION 5

RECEIVED
JUN 24 1997
BY

TO THE APPLICANT

Complete the identifying information below and submit to:

Federation of State Medical Boards
400 Fuller Wiser Road
Euless, TX 76039-3855

Attention: Barbara Rains
Board Inquiry Specialist

Department of Health
Medical Quality Assurance Commission
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 Quality Assurance Commission. Thank you for your assistance.

NAME: JENNIFER L MELVILLE

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

MEDICAL SCHOOL OF GRADUATION: UNIV OF CALIFORNIA, LOS ANGELES

YEAR OF GRADUATION: 1995

BIRTHDATE: 5/02/69

RESPONSE:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

JUL 01 1997

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

DOH 657-072 (Rev. 02/96)

American Medical Association

Physicians dedicated to the health of America

Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

Name and Address:

JENNIFER LYNN MELVILLE MD
2101 2ND AVE N
SEATTLE WA 98109 USA

Phone: UNKNOWN
Birthdate: 05/02/1969
Birthplace: PITTSBURGH PA USA

Physician's Major Professional Activity: RESIDENT

Self Designated Practice Specialties (SDPS):
Primary: OBSTETRICS AND GYNECOLOGY
Secondary: UNSPECIFIED

PROCESSED
JUL 21 1997
HEALTH PROFESSIONS
SECTION 5

AMA membership: NOT A MEMBER

Following Data Provided by the Primary Sources

Medical School:
UNIV OF CA, LOS ANGELES, UCLA SCH OF MED, LOS ANGELES CA 90024 (VERIFIED)

Year of Graduation: 1995 (VERIFIED)

Current and/or Prior Medical Training or Fellowship:

Institution: UNIV OF WA SCH OF MED
RESIDENT
Specialty : OBSTETRICS AND GYNECOLOGY

State: WASHINGTON
(VERIFIED)
06/1995 - 06/1999

Note: Additional information, used for appointments and privileges, is not solicited, nor is it received from the residency program directors. If additional information is required, please contact the program director(s).

National Board Certification Year: NONE REPORTED TO DATE

License(s) :

State	MD/ DO	Date Granted	Expiration Date	Status	License Type	As of

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. A blank expiration date indicates that the data is not provided to AMA by the licensing board. Please contact the appropriate licensing board directly for this information.

NONE REPORTED TO DATE

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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 or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency: **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited unless otherwise agreed to in writing by the AMA.** 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.

Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

Federal Drug Enforcement Administration:

TO DATE, FEDERAL DEA REGISTRATION STATUS IS UNKNOWN.

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

Specialty Board Certification(s):

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

Primary Board: NONE REPORTED TO DATE

Effective: **Expires:**

Subcertification or Certificate of Special Competence: NONE REPORTED TO DATE

Effective: **Expires:**

Note: For certfication dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY HCFA.

Other Federal Sanction(s):

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

Additional Information:

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

The content of the Physician Profile is intended as an instrument to assist with credentialing. Appropriate use of the Physician Masterfile data contained on this profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations and the Utilization Review Accreditation Commission. The Physician Masterfile meets the National Committee for Quality Assurance Standards for verification of medical education, residency training and board certfication.

If you note any discrepancies, please mark them on a copy of the profile and return to: American Medical Association Department of Data Services, 515 N. State Street, Chicago, Il 60610.

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 SE Quince St • P.O. Box 47866 • Olympia, WA 98504-7866

June 27, 1997

Jennifer L. Melville, MD
2101 2nd Avenue North
Seattle, Wa 98109

Dear Dr. Melville:

This is to acknowledge receipt of your application to obtain licensure as a physician and surgeon in the state of Washington. According to our records the following items have not been received to complete your application:

Federaton of State Medical Boards
American Medical Association
Medical School Transcripts
Examination Scores
Post Graduate Training

A dificiency letter will be sent every four to six weeks until the application is considered complete. Depending on the complexity of the application file, the review process may take from five to ten working days. If your application contains negative information, it will be reviewed at the next Commission meeting for final disposition.

If you have any questions, please feel free to contact me at (360) 664-8689.

Sincerely,

Deonna

Deonna Berndson,
Licensing Representative

Board of Medical Examiners

Limited Physician Application Worksheet

NAME: Melville, Jennifer

DATE APPLICATION RECEIVED: 5/8/95

DATE OF BIRTH: 5/2/69

DATE APPLICATION COMPLETED: ______

225 Fee | ✓ Photo | ✓ Personal Data | ✓ Aids | ✓ Affidavit

✓ Residency | ___ Fellowship | ___ Teaching/Research | ___ Institutions | ___ City/County

Positive Data Questions ____, ____, ____. Documentation Received ______

✓ Chronology Completed ______ Missing Dates ____ to ____. ____ to ____. ____ to ____.

MALPRACTICE CASE	SYNOPSIS	ORIGINAL COMPLAINT	DISPOSITION
CASE 1 NAME:			
CASE 2 NAME:			

✓ FDB ✓
✓ AMA ✓
___ ECFMG

Medical School ☐ U.S. ☐ Canadian ☐ International ☐ Fifth Pathway

MEDICAL SCHOOL NAME: UCLA ✓ | ✓ Transcript | ___ Translations | YEAR OF DEGREE: 1995

Examination Type ☐ National Board ☐ FLEX ☐ USMLE ☐ State Exam ☐ LMCC Scores Received ___

POSTGRADUATE TRAINING PROGRAM

STATE LICENSURE

HOSPITAL PRIVILEGES

EMPLOYMENT/PROGRAM VERIFICATION

✓	Univ of Wash		

STAFF DECISION

☑ APPROVED
☐ DISAPPROVED

LICENSURE [signature] SIGNATURE 12/4/95 DATE

COMMENTS:

BME 062 (REV. 8/12/93)

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

DEPOSIT CREDIT

Limited Physician

JENNIFER L. MELVILLE — 4/11/95

NAME (Please Print) — DATE

DOH 657-081 (4/94)

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

☑ Check ☐ Money Order

$ 225.–

Please note amount enclosed, and return with your application.

1A 0252140000 00336

000102 05/08/95 22500

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

APPLICATION FOR LIMITED LICENSE TO PRACTICE MEDICINE
Applicable for MD's Only

3837

FOR OFFICE USE ONLY		
CERTIFICATE NO. 4996	ISSUE DATE 12/5/95	EXPIRATION DATE 7/31/96

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

- ☐ Institutional
- ☐ Fellowship - 2 year limit
- ☐ County-City Health Department
- ☒ Internship-Residency
- ☐ Teaching-Research - 2 year limit

PLEASE TYPE OR PRINT CLEARLY

Applicant's Name MELVILLE (LAST) JENNIFER (FIRST) L (MIDDLE INITIAL)

Name of Institution/Health Dept/Medical School/Hospital UNIV OF WASHINGTON MEDICAL CENTER

Address DEPT OF OB/GYN, RH-20

City SEATTLE State WA ZIP 98195

Telephone No. (206) 543-9626
ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.

Social Security Number 1 - DOH Licensee Social Security Number ...
REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND NOT REQUIRED FOR LICENSING APPROVAL.

Sex (F or M) F Birthdate 05 (MONTH) 02 (DAY) 69 (YEAR)

Birthplace PITTSBURGH (CITY) PA (STATE) USA (COUNTRY)

Medical specialty OBSTETRICS & GYNECOLOGY

Medical School Attended UCLA (NAME/COUNTRY) Year of Graduation 1995

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

Have you previously applied for a Washington State Medical License or limited license? ☐ Yes ☒ No

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.

PERSONAL DATA

	Question	Yes	No
1.	Have you ever had a license to practice medicine suspended, revoked, restricted or denied or voluntarily surrendered a physicians license in any state, federal or foreign jurisdiction?	☐	☒
2.	Have you ever had hospital privileges, or medical society membership revoked, suspended, restricted or denied 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.	Have you ever been notified that any information pertaining to you been submitted to the National Data Bank?	☐	☒
6.	Have you ever been denied a DEA registration number or been issued a restricted DEA registration or voluntarily surrendered a DEA registration?	☐	☒
7.	To the best of your knowledge, are you the subject of an investigation by any licensing board as of the date of this application?	☐	☒
8.	Have you ever agreed to restrict your practice in lieu of or to avoid formal action?	☐	☒

If response to 1-8 is affirmative, attach certified copies of orders, stipulations, agreements, charges, judgements sentences, findings and nature of decisions. If on parole or probation, include a letter from the supervising officer indicating progress.

	Question	Yes	No
9.	Have you ever been found guilty of the violation of any drug law, or prescribing controlled substances for yourself or been found guilty of a traffic citation involving drug or alcohol?	☐	☒
10.	Have you ever been involved in the possession, use, prescription for use, or diversion of controlled substances or legend drugs in any other way than for legitimate or therapeutic purposes?	☐	☒
11.	Have you ever submitted or been required to submit for treatment for alcohol dependency?	☐	☒

If response to 9 through 11 is affirmative, attach copies of charges, sentences, orders, stipulation and/or dispositions. Also include letters from the treating professional and/or institution stating details of condition or addiction, treatment and prognosis.

	Question	Yes	No
12.	Have you ever received treatment for a mental illness?	☐	☒
13.	Have you ever been released from or restricted in a medical program because of a mental condition or illness?	☐	☒
14	Are you currently afflicted with a mental or physical condition which impairs or restricts your ability to practice with reasonable skill and safety?	☐	☒

If response to 12 through 14 is affirmative, attach copies of letters from treating professional, program and/or institutions describing diagnosis, treatment and prognosis. This information is treated as confidential and exempt from public disclosure unless formal disciplinary action is taken against your application on the basis of a mental or physical condition impairing your ability to practice with reasonable skill and safety.

	Question	Yes	No
15.	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

RCW 18.130.180(2)

MELVILLE, JENNIFER MD_00035251 PAGE 29

IDENTIFICATION

HEIGHT 5'7"	WEIGHT 135
COLOR OF EYES BLUE	COLOR OF HAIR BLONDE

n
ofile
ceptable

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 ENTRANCE DATE MO./YR.	ATTENDANCE LEAVING DATE MO./YR.	DIPLOMA OR DEGREE OBTAINED QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH
Medical Education (List all Medical Schools Attended)				
UCLA	4	8/91	5/95	M.D.
Post-Graduate Training (List all programs attended)				

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.	INCLUSIVE DATES OF EXPERIENCE ENDING MO./YR.
Ø		

Please list hospitals in the US or Canada 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
Ø		

MELVILLE, JENNIFER MD_00035251 PAGE 30

LICENSES IN OTHER STATES/COUNTRIES

List all licenses to practice medicine in any state, Canadian province or other country. (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		
Ø						

AID'S 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 246-917-060)

Jennifer L Melville
SIGNATURE

04/11/95
DATE

APPLICANT'S ATTESTATION

I, JENNIFER L. MELVILLE, 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 may request a physical or mental evaluation to determine my fitness for practice.

Jennifer L Melville
SIGNATURE OF APPLICANT

04/11/95
DATE

MELVILLE, JENNIFER MD_00035251 PAGE

MAY 18 1995
DEPT OF HEALTH

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

Attention: Barbara Rains
Board Inquiry Specialist

MAY 10 1995

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: JENNIFER L. MELVILLE

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

MEDICAL SCHOOL OF GRADUATION: UCLA

YEAR OF GRADUATION: 1995

BIRTHDATE: 05/02/69

RESPONSE:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN
MAY 16 1995
James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

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

WA

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
515 NORTH STATE STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES — DATE: 05-16-95
DEPARTMENT OF PHYSICIAN DATA SERVICES — TIME: 7:18 PM

NAME: MELVILLE, JENNIFER LYNN, M.D.
ADDRESS: 2101 2ND AVE N
SEATTLE WA 98109
BIRTHPLACE: PITTSBURGH, PA
BIRTHDATE: 05/02/69
MEMBER OF AMA: 1995 ACTIVE MEMBER THRU CA
MEDICAL SCHOOL: 005-14
UNIV OF CA, LOS ANGELES, UCLA SCH OF MED, LOS ANGELES CA 90024
YEAR OF GRADUATION: 1995
LICENSES (INITIAL YEAR GRANTED BY STATE):
NONE REPORTED TO DATE
NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

MEDICAL UNIT
MAY 19 1995
RECEIVED

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

CURRENT MEDICAL TRAINING: RESIDENT
HOSPITAL: UNIV OF WA SCH OF MED SEATTLE WA 98195
DATES OF TRAINING: 07/95-06/96 -- (NOT CONFIRMED)
SPECIALTY: OBSTETRICS AND GYNECOLOGY
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 1995 AMERICAN MEDICAL ASSOCIATION. SEE REVERSE. ****AMA FILES CHECKED

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.

1300 SE Quince St.
Olympia, WA 98504
206-753-2999 or 753-2205

CA 3837

Board of Medical Examiners

Residency Certification

This is to certify that JENNIFER LYNN MELVILLE has been

appointed as a resident* in OBSTETRICS & GYNECOLOGY at
SERVICE

the UNIVERSITY OF WASHINGTON hospital for the period

beginning 06 26 95. The individual responsible for this resident's patient care activities
MONTH DAY YEAR

will be ______________________.
(SIGNATURE) DIRECTOR OF PROGRAM

* Residents 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)

DOH 657-057 (Rev. 3/91)

- Board of Osteopathic Medicine & Surgery
- Certified Respiratory Care Practitioners
- Health Care Assistants
- Medical Quality Assurance Commission
- Podiatric Medical Board
- Radiologic Technology Program

STATE OF WASHINGTON

Department of Health

Health Professions Section Five

1300 SE Quince St, MS 7866, Olympia, WA 98504-7866

August 22, 1995

Jennifer Melville
University of Washington
PO BOX 356340

Dear Dr. Melville:

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:

Medical School Transcripts

Upon reeceipt 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 (360) 664-8689.

Sincerely,

Dirk Gillespie
Program Representative

Application File_446048_pdf-r.pdf redacted on: 12/11/2014 16:17

Redaction Summary (5 redactions)

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1 Privilege / Exemption reason used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (5 instances)

Page 5, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 9, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 19, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 28, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 32, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance