

CERT NO. 15182	ISSUED 7-1-76
Div. 7-1-76	7-23-74
PIC #	

STATE OF WASHINGTON
 DIVISION OF PROFESSIONAL LICENSING
 P.O. BOX 649
 OLYMPIA, WASHINGTON 98504

RECEIVED

MAR 30 1976

APPLICATION FOR LICENSE TO PRACTICE MEDICINE

DIVISION OF PROFESSIONAL LICENSING

PLEASE TYPE OR PRINT CLEARLY

NAME Korff Marianne Louise Twyman F mo. 3 day 9 yr. 49
last first middle sex birthdate

ADDRESS 4040 8th Ave NE #201 BIRTHPLACE Ashland, OR
street city state county

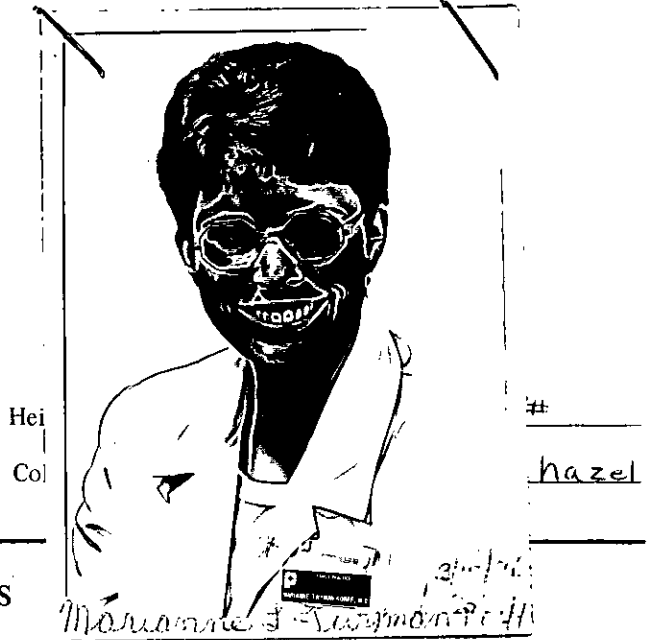
Seattle
city

WA 98105
state zip

Application is made for licensure by

- A. National Board waiver
- B. L.M.C.C.
- C. Flex waiver
- D. Reciprocity from _____ state
- E. Examination

ALL APPLICANTS FOR EXAMINATION MUST SUBMIT **3** PHOTOGRAPHS WITH THE APPLICATION.



INSTRUCTIONS

1. This application, together with supporting documents, must be filed with the Division of Professional Licensing, P.O. Box 649, Olympia, Washington 98504 at least thirty days prior to the board meeting at which it is to be reviewed or by April 1 for the June examination and October 1 for the December examination.
2. Please type or print clearly in ink.
3. Answer all questions. If answer is "no" or "none", so state.
4. If additional space is required, attach separate sheets, indicating section to which they refer.
5. All applicants must provide the following:
 - (1) Copy of diploma issued by a medical school approved by the Board of Medical Examiners.
 - (2) Certificate showing completion of one year of postgraduate medical training in a program acceptable by the Board.
6. Foreign medical graduates must submit proof of medical school curriculum meeting the requirements of the Washington Medical Practice Act, RCW 18.71.055.
7. Foreign medical graduates must provide their original standard E.C.F.M.G. certificate before licensure.
8. COPIES OF ALL DOCUMENTS MUST BE CERTIFIED AS TRUE.
9. ALL SUPPORTING DOCUMENTS MUST BE NO LARGER THAN 8½"x11".
10. See accompanying EXCERPTS for detailed information.

2696 70 300376

50.00

3. CERTIFICATION

Applicants for licensure by NATIONAL BOARD OF MEDICAL EXAMINERS WAIVER must furnish an original copy of "Certification of Record". This has been sent to National Board of Medical Examiners as required.

They will forward a copy.

Applicants for licensure by FLEX WAIVER must furnish examination results directly 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 aforesaidin h..... examination before the

of this state attained a general average of.....per cent or FLEX WEIGHTED AVERAGE OFpercent 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 BASIC SCIENCES..... DAY II CLINICAL SCIENCES..... DAY III 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

4. PERSONAL DATA

If any of the following questions are answered "Yes", full details must be furnished on separate sheet and attached.

- 1. Do you hold a license in any of the other healing arts?..... yes no
- 2. Have you ever been called before any state board for interrogation concerning any violation of the Medical Practice Act or unethical conduct?..... yes no
- 3. Have you ever had a license to practice medicine revoked or suspended?..... yes no
- 4. Have you ever been convicted of a felony or misdemeanor other than traffic violations?..... yes no
- 5. Have you ever been addicted to or treated for addiction to narcotic drugs?..... yes no
- 6. Have you ever been convicted of a violation of the Harrison Narcotic Law, or any narcotic law?..... yes no
- 7. Have you ever received psychiatric treatment or received treatment for a mental illness?..... yes no
- 8. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism?..... yes no
- 9. Have you ever taken the Washington State Medical Examination?..... yes no

5. LETTERS OF RECOMMENDATION

To: DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have known Ms. Marianne
Korff, M.D. for 1 years,
applicant's name in full
from 1/75 to 3/76, during
which period... she was engaged in the study or active practice
of medicine. To the best of my knowledge... she is of good
moral and professional character, is free from habits which
might interfere with her professional activities and is worthy
of holding a license to practice medicine in the State of
Washington.
Signature: Richard H. Layton, M.D.
Address: RICHARD H. LAYTON, M.D., DIRECTOR
PROVIDENCE FAMILY PRACTICE RESIDENCY
1715 E. CHERRY
SEATTLE, WA 98122
Licensed under the laws of Washington
To practice Med Surg

Subscribed and sworn to before me this 15th day of
March, 19 76
Bonnette T. Aweeney
Notary Public for the State of Washington
Residing at Seattle

(NOTARY SEAL HERE)

To: DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have known Marianne
Korff, M.D. for 1 years,
applicant's name in full
from 1/75 to 3/76, during
which period... she was engaged in the study or active practice
of medicine. To the best of my knowledge... she is of good
moral and professional character, is free from habits which
might interfere with her professional activities and is worthy
of holding a license to practice medicine in the State of
Washington.
Signature: Henry R. Fox, M.D.
Address: 1715 E. Cherry St, Seattle
Licensed under the laws of Washington
To practice medicine - surg

Subscribed and sworn to before me this 15th day of
March, 19 76
Bonnette T. Aweeney
Notary Public for the State of Washington
Residing at Seattle

(NOTARY SEAL HERE)

6. AFFIDAVIT

I, Marianne Louise Twyman Korff, being first duly sworn, depose and say that I am the person described and identified ;
print or type full name of applicant
that I have not engaged in any of the acts prohibited by the statutes of the State of Washington, particularly those acts set forth in
Chapter 18.71 RCW; 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, fed-
eral or foreign) to release to this licensing Board any information, files or records required by the Board for its evaluation of my pro-
fessional, 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 fur-
nish 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 medicine and surgery in the State of Washington.

Subscribed and sworn
to before me this 15th day of March, 19 76
Bonnette T. Aweeney
Notary Public for Washington

Marianne S. Twyman Korff
signature of applicant

My commission expires: May, 1977

ALL APPLICATIONS MUST BE ACCOMPANIED BY APPLICABLE FEE. FEES ARE NON-REFUNDABLE

Schedule of Fees	Application	Examination	State Reciprocity or L.M.C.C.	National Board (Waiver)	Flex Waiver
	\$25.00	\$100.00	\$50.00	\$50.00	\$50.00

ALL APPLICANTS MUST SUBMIT THE APPLICATION FEE IN ADDITION TO THE EXAMINATION/RECIPROCITY/ NATIONAL
BOARD OR FLEX WAIVER FEE APPLICABLE TO COMPLETE THE REQUIREMENTS FOR LICENSURE.
TWYMAN, MARIANNE MD_00015182 PAGE 4

Cert. No. 12-15-75	Issued 131
Pic/Cis Number	

STATE OF WASHINGTON
DIVISION OF PROFESSIONAL LICENSING
P.O. BOX 649
OLYMPIA, WASHINGTON 98504

RECEIVED
APPLICATION LICENSE
FEE \$40.00
NOV 17 1975
DIVISION OF
PROFESSIONAL LICENSING

APPLICATION FOR LIMITED LICENSE
TO PRACTICE MEDICINE.

-PLEASE TYPE OR PRINT CLEARLY IN INK-

APPLICANT NAME TWYMAN-KORFF MARIANNE SEX F
last first middle

BIRTHDATE 3 9 49 BIRTHPLACE Ashland O.R.
month day year city state county

APPLICATION IS MADE FOR LIMITED LICENSURE IN CONJUNCTION WITH EMPLOYMENT IN:

INSTITUTIONS

COUNTY-CITY HEALTH DEPT.

RESIDENCY or INTERNSHIP



EMPLOYER NAME Providence Family Medical Center

ADDRESS 1715 E. Cherry
street
Seattle
city
Wa. 98122
state zip

1. PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience including college and/or university, medical school, internships, residencies and practice. Include ALL periods of time including medical school to present, whether or not engaged in activities related to medicine. INCLUDE THE MONTH/DAY/YEAR in CHRONOLOGICAL ORDER. Use attached sheets if necessary.

FROM mo/day/yr	TO mo/day/yr	Name and Location of Institution, Place of Practice or Other	Degree/Certificate & Date Rec'd, or nature of experience
9-67	6-68	Clark College	-
9-68	6-71	University of Wash	BS
9-71	6-75	Loma Linda Medical School	MD
6 ²⁴ -75	PRESENT	PROVIDENCE MEDICAL CENTER SEATTLE WA.	FAM. MED. RESIDENCY

2. MEDICAL LICENSURE

List licenses applied for or held, currently or in the past. Use attached sheets if necessary.

State or Other	Certificate Year No.	Permanent or Temporary	License Received by: Examination Other	Currently in Force

NOV 17 75 AM 3:24 PM \$40.00

3. PERSONAL DATA

If any of the following questions are answered "Yes", full details must be furnished on separate sheet and attached.

- 1. Do you hold a license in any of the other healing arts? No
- 2. Have you ever been called before any state board for interrogation concerning any violation of the Medical Practice Act or unethical conduct? No
- 3. Have you ever had a license to practice medicine revoked or suspended? No
- 4. Have you ever been convicted of a felony or misdemeanor other than traffic violations? No
- 5. Have you ever been addicted to or treated for addiction to narcotic drugs? No
- 6. Have you ever been convicted of a violation of the Harrison Narcotic Law, or any narcotic law? No
- 7. Have you ever received psychiatric treatment or received treatment for a mental illness? No
- 8. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism? No

4. LETTERS OF RECOMMENDATION

To: Division of Professional Licensing
State of Washington

This is to certify that I have known _____

MARIANNE TWYMAN KORFF for 1 years,

from Sept 74 to Nov 75, during which period.....he was engaged in the study or active practice of medicine. To the best of my knowledge.....s.he is of good moral and professional character, is free from habits which might interfere with h.h...professional activities and is worthy of holding a license to practice medicine in the State of Washington.

Signature [Signature]

Address 1715 E. CHERRY SEATTLE, WA.

Licensed under the laws of WASHINGTON
name of state

To practice MED - SURG.

To: Division of Professional Licensing
State of Washington

This is to certify that I have known _____

MARIANNE TWYMAN KORFF for 4 years,

from AUGUST to NOV., during which period....She was engaged in the study or active practice of medicine. To the best of my knowledge.....s.he is of good moral and professional character, is free from habits which might interfere with h.h...professional activities and is worthy of holding a license to practice medicine in the State of Washington.

Signature [Signature]

Address 1715 E. CHERRY SEATTLE, WA.

Licensed under the laws of WASHINGTON
name of state

To practice MED - SURG.

5. AFFIDAVIT

I, MARIANNE TWYMAN KORFF, being first duly sworn, depose and say that I am the person described and identified;
print or type full name of applicant

that I have not engaged in any of the acts prohibited by the statutes of the State of Washington, particularly those acts set forth in Chapter 18.71 RCW; 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 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 medicine and surgery in the State of Washington.

Subscribed and sworn to before me

this 11 day of NOV. 1975

[Signature]

Notary Public for Washington

My commission expires: May, 1977

Signature of applicant [Signature]

- GENERAL INSTRUCTIONS
- | | |
|--|---|
| Institutions and County/City Health Dept. | Residents |
| 1. Certified copy of medical school diploma | 1. Certified copy of medical school diploma |
| 2. Certified copy of one year of postgraduate training | 2. Fee |
| 3. Certification of licensure status from another state. | |
| 4. Fee | |

MEDICAL BOARD WORKSHEET

"LIMITED LICENSE"

NAME TWYMAN-KORFF, Marianne

DATE OF RECEIPT 11-17-75

1. APPLICATION IN CONJUNCTION WITH:

a) Institutions:

Name _____

State license _____

b) County-City Health Dept.:

Name _____

State license _____

c) Residency:

Hospital Providence

2. FEE:

3. PROOF OF EDUCATIONAL EXPERIENCE:

a) Medical School Diploma

Rec'd

b) Certification of postgraduate training

c) Verification of employment

4. PERSONAL DATA:

5. LETTERS OF RECOMMENDATION:

6. AFFIDAVIT:

7. AMA CLEARANCE: Mld. _____

ADMINISTRATIVE RECOMMENDATION: _____

BOARD ACTION

LICENSE

EXAM

APPROVED

DISAPPROVED

DATE

12-12-75

PENDING

REVIEWED BY

BMH

PROFESSIONAL LICENSING DIVISION

Business & Professions Administration

P.O. Box 649

Olympia, Washington 98504

JACK G. NELSON, Director



This is to certify that Marianne^{L.} Twyman-Korff, M. D. has been appointed as a resident* in Family Practice at Service the Providence Medical Center hospital for the year 1975-76.

The individual responsible for this resident's patient care activities will be Richard H. Layton
Director of Program
(Signature)

Richard H. Layton, M. D.

*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

I hereby certify that this is a true and correct copy of said document.

Sworn and subscribed to before me this 5th day of December, 1975

Marianne Louise Korff
Annette Sweeney, Notary Public
In and for the State of Washington
Residing at Seattle

Loma Linda University

SCHOOL OF MEDICINE

BE IT KNOWN THAT THE BOARD OF TRUSTEES OF THE UNIVERSITY ON THE RECOMMENDATION OF THE FACULTY AND BY THE AUTHORITY OF THE STATUTES OF THE STATE HAS CONFERRED ON

MARIANNE LOUISE KORFF

THE DEGREE

DOCTOR OF MEDICINE

WITH ALL THE PRIVILEGES AND OBLIGATIONS THERETO PERTAINING

GIVEN AT LOMA LINDA IN THE STATE OF CALIFORNIA
THIS FIFTEENTH DAY OF JUNE, NINETEEN HUNDRED SEVENTY-FIVE.

Paul P. Wilson
CHAIRMAN OF THE BOARD OF TRUSTEES



V. Notkoff
PRESIDENT OF THE UNIVERSITY
David Blumenthal
DEAN OF THE SCHOOL OF MEDICINE

November 21, 1975

Marianne Twyman-Korff, M.D.
Providence Family Medical Center
1715 E. Cherry
Seattle, Washington 98122

Dear Dr. Twyman-Korff

This is to acknowledge receipt of your medical, Limited License application received in this office November 17, 1975. The next meeting of the Board will be held on December 12, 1975 at which time your application will be reviewed, if complete. You will be advised of board decision approximately two (2) weeks after the board meeting.

Application appears complete ()

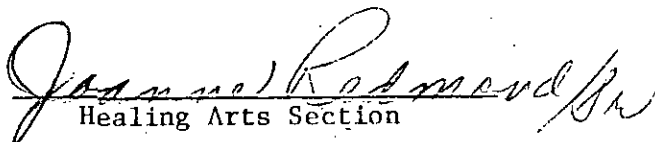
Lacks the following:

- Certified copy of medical school diploma
 - Certification of postgraduate training
 - Fee
 - Certification of license in another state
 - Chronology
 - Letters of recommendation
 - Affidavit
 - Personal Data
 - Verification of employment
 - Other _____
-
-

Copies of all documents must be certified as true and unaltered copies of the originals. Applications not complete prior to board meeting date indicated above, will not be reviewed.

Sincerely

By:


Healing Arts Section

MEDICAL BOARD WORKSHEET

NAME KORFF, Marianne Louise

DATE OF RECEIPT 3-30-76

1. LICENSURE BY

a) National Board Waiver

Rec'd AF

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

** Rec'd*

c) Chronology

d) Personal Qualifications

5. FOREIGN GRADUATE

a) ECFMG

b) Medical School Subjects

6. LETTERS OF RECOMMENDATION

7. AFFIDAVIT

8. STATE CLEARANCE Mid. _____ None

9. AMA CLEARANCE Mid. 3-30-76

ADMINISTRATIVE RECOMMENDATION 1-A + B

BOARD ACTION

LICENSE

EXAM _____

APPROVED _____

DISAPPROVED _____

DATE 5/7/76

PENDING Satisf. 1a + 4b

REVIEWED BY JRC

July 6, 1976

Marianne L. Korff, M.D.
4040 8th Avenue N.E. #201
Seattle, WA 98105

Dear Dr. Korff:

We are pleased to advise that you have been issued Washington State Physician and Surgeon certificate No. 15182, dated 7-1-76. 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 you notification of your license renewal thirty (30) days prior to expiration date. Please review the enclosed insert. It is important that you keep our office advised of any changes in your address so that you will receive your certificate and annual renewal notices.

Sincerely,

KENNETH C. DIEHL
ADMINISTRATOR

By (Mrs.) Joanne Redmond
Executive Secretary, Healing Arts

JR:jkw

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

MARIANNE TWYMAN KORFF, 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: John S. Millis
Chairman of the Board

SEAL Robert A. Chase
President of the Board

Philadelphia, Pa.
07/01/76 Cert. # 158425

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of **LOMA LINDA U SCH OF MED** in **SEPTEMBER 1974**, whose birth date is **03/09/1949**, 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
PART I passed <u>06/73</u>		
Anatomy, incl. histology and embryology	580	86
Physiology	525	82
Biochemistry	565	85
Pathology	630	89
Microbiology, incl. immunology	570	85
Pharmacology and Materia Medica	490	80
Behavioral Sciences	770	98
(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**	605	86
Part II passed <u>09/74</u>		
Internal medicine and the medical specialties	570	86
Surgery and the surgical specialties	665	90
Obstetrics and Gynecology	690	91
Public Health and Preventive Medicine	685	91
Pediatrics	655	90
Psychiatry	730	93
(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**	705	90
PART III passed <u>03/76</u>		
A General Test of Clinical Competence		
(Minimum Passing Grade 290/75) AVERAGE	625	86.7
GENERAL AVERAGE (Parts I, II, and III)		87.6 (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.

Ann K. Severling
Secretary for Certification,
05/26/76

SEAL

Date

Marianne S. Twyman Korff

I hereby certify that this is a true and correct copy of said document.

Sworn and subscribed to before me this 10th day of June, 1976

Anneth T. Auer
Notary Public in and for the State of Washington, residing at Seattle

RECEIVED
JUN 16 1976
DIVISION OF LICENSING

Providence Medical Center

Seattle, Washington
Sisters of Providence in Washington

This Certifies That

Marianne L. Twyman Korff, M.D.

having served as

First Year Family Medicine Resident

June 25, 1975 to June 24, 1976

Presented in appreciation for his loyalty and effort in working for the improvement of the Hospital and its services is awarded this

Certificate

In witness whereof, we have affixed our hands and the seal of the hospital

[Signature]
President, Medical Staff
[Signature]
Director of Programs

[Signature]
Administrator
[Signature]
Director of Medical Education

PROFESSIONAL LICENSING DIVISION

Business & Professions Administration

P.O. Box 649

Olympia, Washington 98504

JACK G. NELSON, Director



May 18, 1976

Marianne L. Korff, M.D.
4040 8th Avenue NE #201
Seattle, WA 98105

Dear Dr. Korff:

Your application and documents were presented to the Board of Medical Examiners on May 7, 1976 for review.

No further action can be taken on your application until receipt of the following:

National Board "Certification of Record", showing subjects and grades.

Certified copy of postgraduate training.

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

Sincerely,

KENNETH C. DIEHL
ADMINISTRATOR

By: (Mrs.) Joanne Redmond
Assistant Administrator
(206) 753-2205

JR:jkw

April 1, 1976

Marianne L. Korff, M.D.
4040 8th Avenue NE #201
Seattle, WA 98105

Dear Dr. Korff:

Thank you for your medical application received in this office March 30, 1976.
The next meeting of the Board will be held on May 7, 1976
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 (x)

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.

Remarks: We will need the original copy of your National Board

"Certification of Record" showing your subjects and grades.

A certified copy ~~of your~~ postgraduate training must be presented
before licensure.

Sincerely,

By _____

Healing Arts Section

MED-657-14 App. Rec'd Ltr.
(R/9/75)



Providence Family Medical Center 

PROVIDENCE MEDICAL CENTER
1715 E. CHERRY • SEATTLE, WA. 98122 • (206) 326-5581
~~(206) 326-5581~~
(206) 326-5581

April 8, 1976

Division of Professional Licensing
Medical Section
P.O. Box 649
Olympia, Washington 98504

Attention: Joanne Redmond

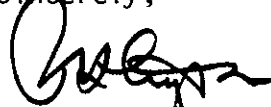
Dear Ms. Redmond:

This is to certify that Marianne Twyman Korff, M. D. will complete one year of postgraduate training as a first year resident in Family Practice at Providence Medical Center in June of 1976.

Her certificate is in the process of printing at the present time. A certified copy of her certificate will be forwarded to you when it becomes available to us.

Please include this letter in the file of Marianne Twyman Korff, M.D.
Thank you very much.

Sincerely,



Richard H. Dayton, M. D.
Director
Providence Family Practice
Residency Program

RHL:s
4-8-76

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT
DEPARTMENT OF PHYSICIAN STATISTICS

DATE: 04-05-76

TIME: 11:18 AM

NAME: KORFF, MARIANNE TWYMAN, M.D. MEDICAL EDUCATION NUMBER: 00512742084
ADDRESS: 4040 8TH AVE N E APT 201 SEATTLE WA 98105

BIRTHPLACE: ASHLAND, OR BIRTHDATE: 03/09/49

MEDICAL EDUCATION (SCHOOL YEAR):

✓ LOMA LINDA UNIVERSITY SCHOOL OF MEDICINE, LOMA LINDA LOS ANGELES 1974

NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE

LICENSES:

NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES:

INTERN

PRIMARY SPECIALTY: UNSPECIFIED

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: INTERN

✓ HOSPITAL: PROVIDENCE MED CENTER SEATTLE 98122

DATES OF TRAINING: 06/75-06/76

SPECIALTY: FAMILY PRACTICE

SPECIALTY: UNSPECIFIED

INTERNSHIP:

NONE REPORTED TO DATE

RESIDENCY:

NONE REPORTED TO DATE

*** AMA FILES HAVE BEEN CHECKED ***

BIOGRAPHICAL DATA ON PHYSICIANS
from the files of
The American Medical Association
535 No. Dearborn St.
Chicago, Illinois 60610

To: Corresponding Officer of Medical Licensing Board:
This form is provided for your convenience in making routine inquiries regarding physicians seeking medical licensure in your state. Please enter on this form date you wish verified and mail to the Circulation and Records Department of the A.M.A.

Executive Officer's Name: KENNETH C. DIEHL, ADMINISTRATOR
Professional Licensing Division
P. O. Box 649
Olympia, Washington 98504

Date: March 30, 1976

Full name of licensure candidate: Marianne Louise (Twyman) KORFF

Place of birth: Ashland, OR Date of birth: 3-9-49

Mailing address: 4040 - 8th Ave. NE, #201, Seattle, WA, 98105

Medical Education - School: Loma Linda University

M.D. Degree (Year): 1975

Present Application for Licensure:

Examination _____ Reciprocity _____ State _____

Endorsement of Credentials National Board Waiver

I hereby certify that this is a true and correct copy of said document

Sharon L. Rossen / Marianne T. Twyman Korff

Sworn and subscribed to before me this 15th day of March, 1976

Annette T. Sweeney

Annette T. Sweeney, Notary Public in and for the State of Washington, Residing at Seattle

Loma Linda University

SCHOOL OF MEDICINE

BE IT KNOWN THAT THE BOARD OF TRUSTEES OF THE UNIVERSITY ON THE RECOMMENDATION OF THE FACULTY AND BY THE AUTHORITY OF THE STATUTES OF THE STATE HAS CONFERRED ON

MARIANNE TWYMAN KORFF

THE DEGREE

DOCTOR OF MEDICINE

WITH ALL THE PRIVILEGES AND OBLIGATIONS THERETO PERTAINING

GIVE AT LOMA LINDA IN THE STATE OF CALIFORNIA THIS FIFTEENTH DAY OF JUNE, NINETEEN HUNDRED AND SEVENTY-FIVE.

Paul P. Wilson
CHAIRMAN OF THE BOARD OF TRUSTEES



V. Norstad Olsen
PRESIDENT OF THE UNIVERSITY

Alan W. Christman, M.D.
DEAN OF THE SCHOOL OF MEDICINE

**PROFESSIONAL LICENSING
DIVISION**

JACK G. NELSON, Director

Business & Professions Administration
P.O. Box 649
Olympia, Washington 98504

This is to certify that Marianne Twyman Korff, M.D. has been
appointed as a resident* in Family Practice R-2 at
Service
the Providence Medical Center hospital for the year 1976-77.

The individual responsible for this resident's patient care activities
will be _____

Richard H. Layton
Director of Program
(Signature)

Richard H. Layton, M.D.

*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

Redaction Summary (0 redactions)

0 Privilege / Exemption reason used:

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