telnet (GothomCity)

```
                        AAAAAA     SSSSSS    IIIIIIIIII
                       AAAAAAA    SSS  SSS   IIIIIIIIII
MEDICAL BOARD               ASSESSMENT SYSTEMS,, INC.                    07-24-02
hab0303                           REAL SYSTEM          V2.5.74           02:30:38 PM
INDIVIDUAL NAME                                (JR,SR,III)      REFERENCE # ML20006661
   LAST WONG                                                    SOC SEC NUM 1 - DOH Licensee Soci...
  FIRST JASON                                +-ADDITIONAL INFORMATION-----------------+
 MIDDLE H                                    |          SEX M =      MARRIED Y =      |
                                             |                                        |
RESIDENCE INFORMATION                        |   OTHER NAME                           |
1525 NW 57TH STREET APT 627                  |CORP. OFFICER                        =  |
SEATTLE WA 98107                             |TRUST ACCOUNT                           |
                                             |                                        |
                                             |  BIRTH PLACE CHICAGO, IL               |
                                             |        DATE 11-21-1974                 |
PHONE: (   )     -       COUNTY:   17        |                                        |
       (   )     -       LGL ST: WA          |SCHOOL CODE                             |
                                             |   CE UNITS    0.00 REQD BY   -  -      |
NOTES                                        +----------------------------------------+

+-------------------------------------------------------------------------------------+
|CURRENT STATUS: A    EXPIRATION DATE: 07-31-2003  FIRST ISSUE DATE: 06-26-2000       |
|RENEWAL STATUS: Z   LAST ACTIVE DATE:   -  -     LAST RENEWAL DATE: 06-12-2002       |
|COMPLAINTS O/C:  0/ 0      AUTHORITY: RE                                             |
+-------------------------------------------------------------------------------------+
1MENU #1  2ADDR DAT 3  ALIAS  4NAME HIS 5         6         7         8FILL BRN
```

DEFICIENCY LETTER LOG SHEET		
ITEM	**Calendar Date**	**Julian Date**
Application Received	7/22	
Deficiency Letter 1	8/24	
Deficiency Letter 2		
Deficiency Letter 3		
Deficiency Letter 4		
Deficiency Letter 5		
Deficiency Letter 6		
Deficiency Letter 7		
Deficiency Letter 8		
Deficiency Letter 9		
Deficiency Letter 10		
Deficiency Letter 11		
Deficiency Letter 12		
Deficiency Letter 13		
Deficiency Letter 14		
Deficiency Letter 15		
Deficiency Letter 16		
Deficiency Letter 17		
Deficiency Letter 18		
Deficiency Letter 19		
Deficiency Letter 20		

DATE	TELEPHONE LOG	INITIALS

Medical Quality Assurance Commission
Physician Application Worksheet

Pending Number _____
License Number _____

Name WONG, JASON H Date of Birth 11/21/1974

Date Received 7/22/2002 Date Complete _____ Signature _____

$100 Fee ✓ Photo x Personal Dat X AIDS X Affidavit X SSN ✓ Archive File

Chronology ✓ Complete Missing: _____ to _____; _____ to _____; _____ to _____

☐ Temporary Permit Requeste _____ Status

PSMB 7/24 AMA 8-1-2002 ECFMG Reinstatement

Personal Data Questions Documentation Received

Malpractice Cases
1 _____
2 _____
3 _____
4 _____

Synopsis	Complair	Original Disposition

Medical School Name ALBERT EINSTEIN Year of Degre 2000 35.46

☐ U.S. ☐ Canadian ☐ International

✓ Transcripts ☐ Translations

Examination Type ☐ National Boar ☐ FLEX ☒ USMLE ☐ State Exan ☐ LMCC 7/29 Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Graduate Training Programs	Accrediation Verified
9/9	UW 6/00- PRESENT				

✓	WAML		

Approved Betty Ellwert 9-12-02
Signature

Comments:

Washington State Department of Health

100—

PHYSICIAN & SURGEON

REVENUE SECTION

PRINT NAME Wong, J

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236

002086 07/18/2002 10000

021992086

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4785
(360) 236-4784

ROUND CHECK PROCESSED
JUL 22 20[illegible]
Department of Health
Investigation Service Unit

FOR OFFICE USE ONLY	
ISSUANCE DATE	
LICENSE #	41655

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

☐ National Boards ☑ Other State Exam ☐ LMCC (must have been obtained after 1969)
☐ FLEX Examination ☒ USMLE Examination

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL
Wong	Jason	H

ADDRESS: 1525 NW 57th St. #627

CITY	STATE	ZIP	COUNTY
Seattle	WA	98107	USA

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	SOCIAL SECURITY NUMBER
(206) 598-4055	1 - DOH Licensee Social Security Number -...

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
☐ Female ☒ Male	11/21/74	Chicago, IL

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

Have you ever been known under any other name(s)? ☐ Yes ☒ No

If yes, list name(s):

HEIGHT	WEIGHT
5'8"	130
EYE COLOR	HAIR COLOR
black	black

MEDICAL SCHOOL	YEAR OF GRADUATION
Albert Einstein College of Medicine	2000

MEDICAL SPECIALITY: Family Medicine

2. PERSONAL DATA QUESTIONS

	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.)		
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 on 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.		
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 on 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.		
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? (Including driving under the influence and reckless driving)	☐	☒
6. Have you ever been found in any civil, administrative or criminal proceedings 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 or legend drugs, violated any drug law, 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 professional?		☒
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 judgments, 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?	☐	☒

2. 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 to 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?	☐	☒

3. 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)				
Albert Einstein	4	8/96	6/00	M.D.
Post-Graduate Training (List all Programs Attended)				

4. 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 sheets if necessary.)

Nature of Experience or Practice	Dates of Experience From (mo/yr)	Dates of Experience To (Mo/Yr)
Resident - University of Washington	6/00	present

5. 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 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)	DATES Ending (mo/yr)
N/A		

6. 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: Examination (Date Passed)	Basis of Licensure: Endorsement	Status of License Active or Inactive	Any Limitations on License
Washington	7/02	025214 -	USMLE 8/01			Limited
		ML2000666				

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

Name and Location of Fifth Pathway Program	Name and Location of Hospital	Dates Attended: Beginning (mo/yr)	Dates Attended: Ending (mo/yr)

8. 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)

APPLICANT'S SIGNATURE — DATE: 6/22/02

9. APPLICANT'S ATTESTATION

I, Jason H. Wong, 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: 6/22/02

Official Use Only

Washington State Records Center

HPQA RECEIVED JUL 19 2002 CSC

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

US·MLE
United States
Medical
Licensing
Examination™

This Transcript was prepared by the Federation of State Medical Boards

RECEIVED JUL 29 2002 Health Professions Section

Date of Certification: 07/25/2002

Washington Medical Quality Assurance Commission
ATTN: Bonnie L. King, Exec Director
PO Box 47866
Olympia, WA 98504-7866

Examinee:	Wong, Jason Huei-Chiang
USMLE ID#:	5-047-235-6
DOB:	11 / 21 / 1974
Alt Name(s):	Wong, Jason H

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	6/9/1998	PASS	205	(179)	83	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	3/2/2000	PASS	210	(170)	84	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
WASHINGTON	8/8/2001	PASS	216	(182)	88	(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.

Patent 5636874

TamperSafe® Patents #5,772,049

CDS 4.00.10 9133312 Page: 1 of 1 TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination scores is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram 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.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

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 each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 75 on the two-digit scale is the recommended 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 USMLE Step 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 be expected to 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 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

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, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

Irregular Behavior - The 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*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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.

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

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

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 ensure that 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, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

Albert Einstein College of Medicine of Yeshiva University

OFFICE OF THE REGISTRAR
Jack and Pearl Resnick Campus
1300 Morris Park Avenue
Bronx, New York 10461
Phone: 718•430•2102/2104
FAX: 718•430•8825
email: lombardi@aecom.yu.edu

June 12, 2000

Washington State Medical
Quality Assurance Commission
P.O. Box 47866
Olympia, Washington 98504-7866

RE: Jason H. Wong, Class of 2000
AECOM Graduate

To Whom It May Concern,

I am pleased to send you herewith the official transcript requested. I believe you will find this adequate. However, if there is any additional information I can provide, please do not hesitate to contact this office.

Very truly yours,

Lillian Lombardi
Registrar

LL/ar
Enclosure

transcript ltr.

ALBERT EINSTEIN COLLEGE OF MEDICINE
YESHIVA UNIVERSITY
Jack and Pearl Resnick Campus
Office of the Registrar

Transcript for: **WONG, JASON H.** Class of: 2000
Matriculated: 1996 Printed: 06/12/2000

1996-1997

Anatomy & Embryology . . . . P	Biochemistry . . . . . P	Cardiovascular Physiology. . P
Cell Biology . . . . . P	Disease Mechanisms . . . . . P	General Physiology . . . . . P
Genetics . . . . . P	Histology. . . . . P	ICM-Intro. to Patient. . . . P
Immunology . . . . . P	Principles Preventive Med. . P	Renal System[1,2,3] . . . . . P

1997-1998

Cardiovascular System[1,3] . . P	Endocrine System[1,2,3] . . . . P	Hematology[1,2,3] . . . . . P
ICM-Clinical Examination . . P	Micro/Infect. Disease[1,3] . . . P	Nervous System & Behavior[1,2,3] P
Parasitology . . . . . P	Reproductive System[1,2,3] . . . P	Respiratory System[1,2,3] . . . P
Rheumatologic Disease[1] . . . P		

1998-1999

Family Medicine Clerkship. . HP	Geriatrics Clerkship . . . . E	Medicine Clerkship . . . . . HP
Obstetrics/GYN Clerkship . . P	Pediatrics Clerkship . . . . HP	Surgery Clerkship. . . . . P

1999-2000

Ambulatory Peds./Jacobi. . . P	Dermatology. . . . . P	
Extramural elective.	Internal/Tropical Med. . . . H	
Family Med. Subinternship. . P	Outpatient Neurology . . . . P	Psychiatry Clerkship . . . . HP

---

1 - Integrated Pathobiology, Epidemiology/preventive Medicine and Radiology
2 - Includes Physiology 3 - Includes Pharmacology.

MD Degree granted June 01, 2000

H=Honors HP=High Pass P=Pass
LP=Low Pass F=Fail I=Incomplete
D=Deferred E=Exempt N=Ungraded
(First Year Courses Pass Only)
(HP/LP -- Third & Fourth Year Courses Only)

Not valid without seal.
Certified by:

Lillian Lombardi
MRS. LILLIAN LOMBARDI
REGISTRAR

THE FAMILY EDUCATION RIGHTS AND PRIVACY ACT OF 1994, AS AMENDED, PROHIBITS THE RELEASE OF INFORMATION FROM THIS TRANSCRIPT WITHOUT PRIOR WRITTEN CONSENT OF THE STUDENT TO WHOM IT MAY CONCERN

OFFICE OF THE REGISTRAR
Albert Einstein College of Medicine
Jack and Pearl Resnick Campus
1300 Morris Park Avenue
Bronx, New York 10461

JUN 12 '00
NY

00.33
H METER 704167

Washington State Medical
Quality Assurance Commission
P.O. Box 47886
Olympia, Washington 98504-7866

JUN 16 2000
WIC Program

98504-7866

TRANSCRIPT
ENCLOSED

ealth

MD

Post Graduate Training Program Director

RECEIVED
SEP 9 2002
Health Professions Section 5

FACILITY NAME: ~~FAMILY MEDICINE RESIDENCY PROGRAM~~ UWMC AT ROOSEVELT

ADDRESS: ~~4245 ROOSEVELT WAY NE, BOX 354775~~ SEATTLE, WA ~~98105~~

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 show below. **All questions must be answered.**

Jason Wong — APPLICANT (PRINT OR TYPE)

11/21/74 — BIRTHDATE

SIGNATURE OF APPLICANT

1. Jason Wong, MD is or was engaged in post-graduate training in our program from 6/26/00 (BEGINNING DATE (MONTH & YEAR)) to Active 6/30/03 (ENDING DATE (MONTH & YEAR)) in the field of Family Practice

2. **At the time this individual completed training, was this program accredited through the Accreditation Council for Graduate Medical Education?** ☒ Yes ☐ No

3. **Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evaluations conducted.)** Dr Wong is an excellent physician.

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

5. **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.

6. 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) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(Seal)

Signature Valerie F Cox
Title Program Manager
Hospital ~~FAMILY MEDICINE RESIDENCY PROGRAM~~ (PLEASE TYPE OR PRINT)
Address UWMC AT ROOSEVELT
4245 ROOSEVELT WAY NE, BOX 354775
SEATTLE, WA ~~98105~~
Date
Telephone (206) 598-2883

DOH 657-034 (Rev 7/99)

Washington State Department of Health

MD

TO THE APPLICANT

Complete the identifying information below and submit to:

RECEIVED
JUL 24 2002
Health Professions Section

Federation of State Medical Boards
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3855

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

Date: 6/22/02

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 the Washington State Medical Quality Assurance Commission. Thank you for your assistance.

NAME: Jason H. Wong

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

MEDICAL SCHOOL: Albert Einstein

YEAR OF GRADUATION: 2000

BIRTHDATE: 11/21/74

RESPONSE:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

JUL 23 2002

DALE L. AUSTIN
DEPUTY EXECUTIVE VICE PRESIDENT
AND CHIEF OPERATING OFFICER

DOH 657-072 (Rev 1/98)

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Name and Mailing Address:

JASON HUEICHIANG WONG MD
1959 NE PACIFIC ST
SEATTLE WA 98195-0001

Primary Office Address:

SAME AS MAILING ADDRESS

Address shown has been reported undeliverable **Phone:** UNKNOWN

Birthdate: 11/21/1974
Birthplace: CHICAGO, IL UNITED STATES OF AMERICA

Physician's Major Professional Activity: HOSPITAL BASED RESIDENTS - ALL YEARS

Practice Specialties Self Designated by the Physician:

Primary Specialty: FAMILY PRACTICE
Secondary Specialty:

AMA membership: NON MEMBER

Following Data Provided by the Primary Sources

Medical School:
A EINSTEIN COLL OF MED OF YESHIVA UNIV, BRONX NY 10461 (VERIFIED)

Reported Year of Graduation: 2000 (VERIFIED)

Current and/or Prior Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Institution: UNIV OF WA SCH OF MED — **State:** WASHINGTON
Specialty : FAMILY PRACTICE — 06/2000 - 06/2003
(BEING REVERIFIED)

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

National Board of Medical Examiners (NBME) Certification Year: NONE REPORTED TO DATE

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

License(s): State	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
WASHINGTON	MD	06/26/2000	07/31/2002	ACTIVE	LIMITED	06/05/2002

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. Please contact the appropriate licensing board directly for this information.

ECFMG Certfication:

Applicant Number:

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

Federal Drug Enforcement Administration:

FEDERAL DEA REGISTRATION INFORMATION WAS LAST REPORTED TO THE AMA ON 06/04/2002.
DEA REGISTRATION IS VALID THROUGH 05/31/2004.

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:

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:
Effective: **Expiration:** **Last Reported:**

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 THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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.

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Additional Information:

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

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA 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 (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, residency training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please mark them on a copy of the profile and mail or fax to:

Division of Survey and Data Resources
Attn: Physician Profile Unit
515 N. State Street
Chicago, IL 60610
312 464-5199
312 464-5900 (fax)

Medical Quality Assurance Commission
Limited License Application Worksheet

Pending Number _____
License Number _____

Name WONG, JASON H Date of Birth 11/21/1974

Date Received 5/10/00 Date Completed _____ Signature _____

$225.00 Fee [X] Photo [X] Personal Data [X] AIDS [X] Affidavit [X] SSN [ ] Archive File

Chronology Complete [ ] Missing: _____ to _____; _____ to _____; _____ to _____

[X] Residency [ ] Institution [ ] Fellowship [ ] City/County [ ] Teaching/Research

[ ] FSMB [ ] AMA

Personal Data Questions	Documentation Received

Malpractice Cases	Synopsis	Original Complaint	Disposition
1			
2			
3			
4			

Medical School School Code 35.46 [X] U.S. [ ] Canadian [ ] International

Name ALBERT EINSTEIN Year of Degree 2000 [ ] Transcripts [ ] Translations

Examination Type [ ] National Boards [ ] FLEX [ ] USMLE [ ] State Exam [ ] LMCC [ ] Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Graduate Training Programs	Accrediation Verified

Received	State Licensure	Received	Hospital Privileges

Received	Program/Employment Verification	Received	Program/Employment Verification
✓	U OF WA 6/26/00		

Approved Jason Wong Signature 7-10-2000 Date

Comments:

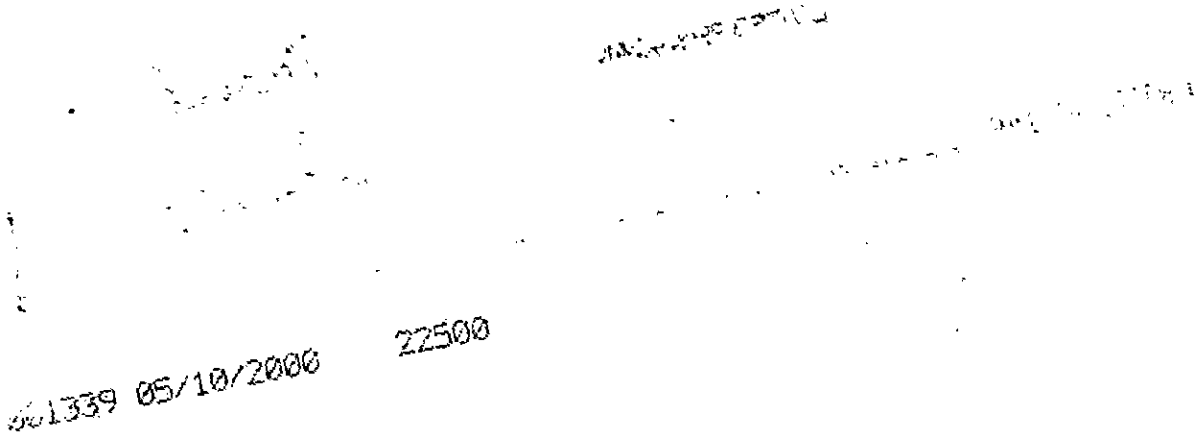
Washington State Department of Health 225

LIMITED PHYSICIAN

REVENUE SECTION

PRINT NAME Wong, J

LF 0252140000 00335


22500
1339 05/10/2000

RECEIVED

MAY 10 2000

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099
(360) 753-2844
(360) 664-3909

FOR OFFICE USE ONLY	
ISSUANCE DATE	
LICENSE #	6661

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

☐ Teaching-Research (2 year limit) ☒ Internship-Residency ☐ Institution
☐ Fellowship (2 Year Limit) ☐ County-City Health Department

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

DEMOGRAPHIC INFORMATION

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL
Wong	Jason	H

NAME OF INSTITUTION/HEALTH DEPT/MEDICAL SCHOOL/HOSPITAL
University of Washington School of Medicine

ADDRESS
Graduate Medical Education, Box 356340 — 1959 N.E. Pacific Street Room A300

CITY	STATE	ZIP	COUNTY
Seattle	WA	98195-6340	King

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-919-030, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS)	SOCIAL SECURITY NUMBER
(718) 822-7880	1 - DOH Licensee Social Security Numb...

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
☐ Female ☒ Male	11/21/1974	Chicago, IL USA

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

Have you ever been known under any other name(s)? ☐ Yes ☒ No

If yes, list name(s):

HEIGHT	WEIGHT
5' 8"	130 lbs

EYE COLOR	HAIR COLOR
black	black

MEDICAL SCHOOL	YEAR OF GRADUATION
Albert Einstein College of Medicine	2000

MEDICAL SPECIALITY
Family practice

Attach... Indicc... Ink Ac...
NOTE:
1. Ori...
2. No...
3. Tak... apl...
4. Cla...
5. Inst... not...

DOH 657-056 (REV 10/97)

2. PERSONAL DATA QUESTIONS

	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.)

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 on 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.

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 on 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.

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? (Including driving under the influence and reckless driving)	☐	☒
6. Have you ever been found in any civil, administrative or criminal proceedings 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 or legend drugs, violated any drug law, 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 professional?	☐	☒
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 judgments, 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?	☐	☒

2. 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 to 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?	☐	☒

3. 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)				
Albert Einstein College of Medicine	4	8/96	6/00	M.D.
Post-Graduate Training (List all Programs Attended)				
N/A				

4. 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 sheets if necessary.)

Nature of Experience or Practice	Dates of Experience From (mo/yr)	Dates of Experience To (Mo/Yr)
N/A		

5. 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 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)	DATES Ending (mo/yr)
N/A		

6. 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						

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

Name and Location of Fifth Pathway Program	Name and Location of Hospital	Dates Attended	
		Beginning (mo/yr)	Ending (mo/yr)

8. 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)

Jason H. Wong — APPLICANT'S SIGNATURE

4/9/00 — DATE

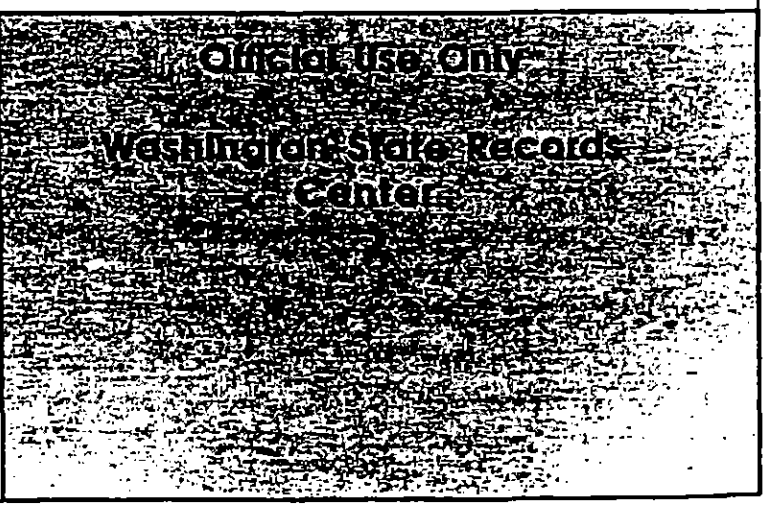
9. APPLICANT'S ATTESTATION

I, Jason H. Wong, 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.

Jason H. Wong — APPLICANT'S SIGNATURE

4/9/00 — DATE



Health
Medical Quality Assurance Commission
1300 SE Quince Street
PO Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Medical Quality Assurance Commission
Residency Certification

This is to certify that JASON H. WONG, MD has been

appointed as a resident* in Dept of Family Medicine, Family Practice Residency at
SERVICE

the University of Washington Medical Center and affiliated hospitals hospital for the period

beginning June 26, 2000. The individual responsible for this resident's
MONTH DAY YEAR

patient care activities will be [signature]
(SIGNATURE) DIRECTOR OF PROGRAM

David P. Losh, MD

* Resident physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.095(3) and is serving a period of post graduate 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.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
1300 SE Quince St • P.O. Box 47866 • Olympia, WA 98504-7866

June 6, 2000

Jason H. Wong, MD
University of Washington
Box 356340
1959 NE Pacific Street Rm A-300
Seattle, WA 98195-6340

Dear Dr. Wong:

This is to acknowledge receipt of your application to obtain a limited license in the state of Washington.

Your application was received on May 10, 2000.

Missing Items:

Medical School Transcripts and Program/Employment Verification

A deficiency letter will be sent every four to five weeks until the application is considered complete. Please understand Commission staff processes a considerable amount of application files at any given time. Deficiency letters are our way of notifying you what is lacking in your file. An over abundance of phone calls simply slow the process down as it diverts staff resources from application processing. We appreciate your consideration of staff resources and your patience with the process.

Depending on the complexity of the application file, the review process may take from 3 to 5 working days for routine applications, an additional 14 working days for applications considered non-routine that must be reviewed by a Commission Member, or, if your application contains derogatory or disciplinary information, it may need to be reviewed by the Full Commission at a Commission meeting for final disposition, in which case the processing time will be longer.

If you have any questions, please feel free to contact me at (360)236-4784.

Sincerely,

Helen A. Bogar,
Program Representative

Albert Einstein College of Medicine of Yeshiva University

OFFICE OF THE REGISTRAR
Jack and Pearl Resnick Campus
1300 Morris Park Avenue
Bronx, New York 10461
Phone: 718•430•2102/2104
FAX: 718•430•8825
email: lombardi@aecom.yu.edu

July 21, 2000

6661

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

RE: Jason H. Wong, M.D.

Dear Sir/Madam:

I am pleased to send you herewith the official transcript requested. I believe you will find this adequate. However, if there is any additional information I can provide, please do not hesitate to contact this office.

Very truly yours,

Lillian Lombardi

Mrs. Lillian Lombardi
Registrar
LL/ra

Enclosure

Washington State Department of Health

MD

REQUEST FOR MEDICAL SCHOOL TRANSCRIPTS

ALBERT EINSTEIN COLLEGE OF MEDICINE
UNIVERSITY MEDICAL SCHOOL

Jack & Pearl Resnick Campus
ADDRESS

1300 Morris Park Ave.

Bronx, NY 10461

I am applying for licensure to practice medicine in the state of Washington. Please send a copy of my medical school transcripts (*with the MD degree and date granted posted*) directly to the Washington State Medical Quality Assurance Commission at the address below. Thank you for your assistance.

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

APPLICANT: Please complete the identifying information below to assist the registrar's office in processing your request.

STUDENT NAME: JASON H. WONG

SSN: 1 - DOH Licensee Soci...

YEAR OF GRADUATION: 2000

BIRTHDATE: 11/21/74

DOH 657-300 (Rev 3/98)

ALBERT EINSTEIN COLLEGE OF MEDICINE
YESHIVA UNIVERSITY
Jack and Pearl Resnick Campus
Office of the Registrar

Transcript for: WONG, JASON H.
Matriculated: 1996

Class of: 2000
Printed: 07/21/2000

1996-1997

Anatomy & Embryology . . . . P	Biochemistry . . . . . P	Cardiovascular Physiology. . P
Cell Biology . . . . . P	Disease Mechanisms . . . . . P	General Physiology . . . . . P
Genetics . . . . . P	Histology. . . . . P	ICM-Intro. to Patient. . . . P
Immunology . . . . . P	Principles Preventive Med. . P	Renal System[1,2,3] . . . . . P

1997-1998

Cardiovascular System[1,3] . . P	Endocrine System[1,2,3] . . . . P	Hematology[1,2,3] . . . . . P
ICM-Clinical Examination . . P	Micro/Infect. Disease[1,3] . . P	Nervous System & Behavior[1,2,3] P
Parasitology . . . . . P	Reproductive System[1,2,3]. . . P	Respiratory System[1,2,3] . . . P
Rheumatologic Disease[1] . . . P		

1998-1999

Family Medicine Clerkship. . HP	Geriatrics Clerkship . . . . E	Medicine Clerkship . . . . . HP
Obstetrics/GYN Clerkship . . P	Pediatrics Clerkship . . . . HP	Surgery Clerkship. . . . . P

1999-2000

Ambulatory Peds./Jacobi. . . P	Dermatology. . . . . P	
Extramural elective.	Internal/Tropical Med. . . . H	
Family Med. Subinternship. . P	Outpatient Neurology . . . . P	Psychiatry Clerkship . . . . HP

---

1 - Integrated Pathobiology, Epidemiology/preventive Medicine and Radiology
2 - Includes Physiology 3 - Includes Pharmacology.

MD Degree granted June 01, 2000

H=Honors HP=High Pass P=Pass
LP=Low Pass F=Fail I=Incomplete
D=Deferred E=Exempt N=Ungraded
(First Year Courses Pass Only)
(HP/LP -- Third & Fourth Year Courses Only)

Not valid without seal.
Certified by:

MRS. LILLIAN LOMBARDI
REGISTRAR

JUL 21 2000

OFFICE OF THE REGISTRAR
Albert Einstein College of Medicine
Jack and Pearl Resnick Campus
1300 Morris Park Avenue
Bronx, New York 10461

BRONX JUL 24'00 NY

U.S. POSTAGE 00.33 : H METER 716082

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

98504-7866

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

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

July 24, 2002

Jason H Wong MD
1525 NW 57th Street Apt 627
Seattle WA 98107

Dear Dr. Wong;

This is to acknowledge receipt of your application to obtain licensure as a physician and surgeon in the state of Washington.

Your application was received on **July 22, 2002.**

Photo dated and signed
Medical School Transcripts
USMLE Scores
Post Graduate Training verifications

A deficiency letter will be sent every four to five weeks until the application is considered complete. Please understand Commission staff process a considerable amount of application files at any given time. Deficiency letters are our way of notifying you what is lacking in your file. An over abundance of phone calls simply slows the process down as it diverts staff resources from application processing. We appreciate your consideration of staff resources and your patience with the process.

If you have any further questions or need additional information, email me at helen.bogar@doh.wa.gov, or write to me at Department of Health, Medical Quality Assurance Commission, P O Box 47866, Olympia, WA 98504-7866.

Sincerely,

Helen Bogar
Licensing Representative

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

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

August 30, 2002

Jason H Wong MD
1525 NW 57th Street Apt 627
Seattle WA 98107

Dear Dr. Wong:

As of this date, our records indicate the following items still have not yet been received in support of your application for a physician license. In order for us to continue to process your application, we will need the documents listed below.

Actual Photo dated and signed
Post Graduate Training verifications

A deficiency letter will be sent every four to five weeks until the application is considered complete. Please understand Commission staff process a considerable amount of application files at any given time. Deficiency letters are our way of notifying you what is lacking in your file. An over abundance of phone calls simply slow the process down as it diverts staff resources from application processing. We appreciate your consideration of staff resources and your patience with the process.

Upon receipt of the above mentioned items, your application will be considered complete and will begin the review process. Depending on the complexity of the application file, the review process may take 3 to 5 working days for routine applications, an additional 14 working days for applications considered non-routine that must be reviewed by a Commission Member, or, if your application contains derogatory or disciplinary information, it may need to be reviewed by the Full Commission. These are reviewed at a Commission meeting for final disposition, in which case the processing time will be much longer.

If you have any further questions or need additional information, email me at helen.bogar@doh.wa.gov, or write to me at Department of Health, Medical Quality Assurance Commission, P O Box 47866, Olympia, WA 98504-7866.

Sincerely,

Helen Bogar
Licensing Representative

Catherine Cooper
Program Manager
UW Family Practice Residency Program

Susan -

Here is the copy of Jason Wong's full licence app pg 1 w/ photo. It also include our resident photo composite that has a little clearer view. - Sincerely

Cathleen Cooper

UWMC Roosevelt, Box 354775
(206) 598-2883
cathcoop@fammed.washington.edu

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4785
(360) 236-4784

HPQA RECEIVED
AUG 0 6 2002
CSC

FOR OFFICE USE ONLY	
ISSUANCE DATE	
LICENSE #	

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

☐ National Boards ☐ Other State Exam ☐ LMCC (must have been obtained after 1969)
☐ FLEX Examination ☒ USMLE Examination

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL
Wong	Jason	H

ADDRESS: 1525 NW 57th St. #627

CITY	STATE	ZIP	COUNTY
Seattle	WA	98107	USA

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	SOCIAL SECURITY NUMBER
(206) 598-4055	1 - DOH Licensee Social Security Number...

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
☐ Female ☒ Male	11/21/74	Chicago, IL

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

Have you ever been known under any other name(s)? ☐ Yes ☒ No

If yes, list name(s):

HEIGHT	WEIGHT
5'8"	130
EYE COLOR	HAIR COLOR
black	black

MEDICAL SCHOOL	YEAR OF GRADUATION
Albert Einstein College of Medicine	2000

MEDICAL SPECIALITY: Family Medicine

University of Washington

Department of Family Medicine

Family Practice Residency Program

2002-2003

First Year

Laura Gottlieb, MD*

Jeff Huebner, MD*

Kelley Kennedy, MD

David Krivan, MD

Ai-Khue Nguyen, MD

Cynthia Ohata, MD

Arthur Wendel, MD

Catherine Zeh, MD

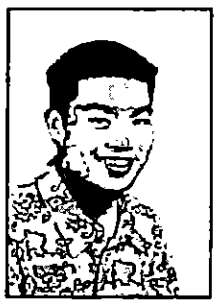
Second Year

Howard Chen, MD*

Casey Crump, MD

Kate Gaynor, MD*

Gloria Kim, MD



Chris Maeda, MD

Lisa Michelbrink, MD

Eduardo Miller, MD

Jackie Raetz, MD

Third Year

Lucy Chen, MD

Joy Cruz, MD*

Christopher Famy, MD*

Chief Resident 7/1/02-6/30/03

Samuel Mitchell, MD

Chief Resident 3/1/03-6/30/03

Stephen Scott, MD

Chief Resident 11/1/02-2/28/03

Catherine Smith, MD

Jason Wong, MD

Chief Resident 7/1/02-10/31/02

Veronika Zantop, MD

* Harborview Satellite

Department of Family Medicine
Family Medicine Residency Program, Box 354775
4245 Roosevelt Way N.E.
Seattle, WA 98105-6920

SEATTLE WA AUG 02'02 PB METER 7116887 =037= U.S. POSTAGE

SUSAN ANTHONY
HEALTH PROFESSIONALS QA DIVISION
P O BOX 1099
OLYMPIA WA 98507-1099

63-5504

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Redaction Summary (6 redactions)

1 Privilege / Exemption reason used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (6 instances)

Page 1, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 7, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 18, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 25, 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
Page 38, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance