Receipt # 082384 50.00

7619 ✓

APPLICATION FOR LICENSE TO PRACTICE

MEDICINE

MONEY CTL. (6, 7, 8)

22613
2-22-85

FOR VALIDATION ONLY

FEES

Medicine with Exam. $125.00
Medicine without Exam Exam. . . . $75.00
Medicine (Having Wash Limited Lic)
With Exam $100.00
Without Exam $50.00
02G-070-252-0009

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

Make remittance payable to:
STATE TREASURER

Note: If you have a Limited License to Practice then the fee with exam is $100.00 and without exam is $75.00

Application for licensure is made by: (Check one)

- ☒ National Board waiver.
- ☐ Reciprocity from (state) _____.
- ☐ Washington Examination. (FLEX)
- ☐ L. M. C. C.
- ☐ Flex waiver.

GA-RC-IJ-M453NL 0 00-00-00
GARCIA, JORGE M F

PROG (1)	TRANS (31)	PROF COD	EXPIRATION DATE (9)	EXPT	STAT(11)	TYPE (12)
LA		252-				

KEY DATE (13)	CLASS (14)	ASSN (15)	BILLED AMOUNT (16)	SIGN	SPLIT	QTRD

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME (20) GARCIA (Last) JORGE (First) M.F. (Middle)

ADDRESS (21) 535 17TH AVE. E. APT 301

CITY (24) SEATTLE STATE (25) WA ZIP (26) 98112 COUNTY (27)

TELEPHONE NO. (39) (206) 323 7583
Enter the number at which you can be reached during normal business hours.

SOCIAL SECURITY NUMBER (40) 1 - DOH Licensee Social Security Numb...
Requested for identification purposes only. Entering SSN is voluntary and is not required for licensing approval.

SEX (F or M) M DATE OF BIRTH 8 (mo.) 13 (day) 1955 (yr.)

BIRTHPLACE RIO DE JANEIRO (City), BRASIL (State/County)

MEDICAL SPECIALTY FAMILY PRACTICE

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

Medical School UNI OF CALIFORNIA, SAN FRANCISCO Year Graduated 1983

INSTRUCTIONS

ALL APPLICANTS

(a) This application and supporting documents, should be filed with the Division of Professional Licensing at least thirty (30) days prior to the board meeting at which it is to be reviewed. (Or for Flex exam by April 1 for the June examination and October 1 for the December examination.)

(b) If additional space is required, attach separate (8½ x 11 inch) sheets indicating the section to which they refer.

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

IDENTIFICATION

HEIGHT	WEIGHT
5' 10"	140 #
COLOR OF EYES	COLOR OF HAIR
BROWN	BROWN

Jorge Garcia

PERSONAL DATA

	YES	NO
1. Have you ever been called before any state or provincial licensing board for interrogation concerning any violation of the laws or regulations pertaining to the profession for which you are applying, or for unethical conduct?	☐	☒
2. Have you ever had a license to practice revoked, suspended, or restricted?	☐	☒
3. Have you ever been denied a license or the right to take an examination for licensing in any state, province, or country?	☐	☒
4. Have you ever had hospital privileges or medical society membership revoked, suspended, or restricted on grounds of unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment?	☐	☒

If the answer to any of the above questions is YES, enclose a letter naming the state, hospital or society, the date of the action, the cause, and the nature of the decision.

5. Have you ever been convicted of or plead guilty to a felony or misdemeanor?	☐	☒
6. Have you ever been convicted of a violation of any state or federal controlled substance act, or any drug or narcotic law?	☐	☒

If the answer to questions 5 or 6 is YES, please enclose a letter giving the date, jurisdiction, and nature of the conviction, as well as the sentence imposed. If still on parole or probation, provide the name and address of the supervising officer.

7. Have you ever used any legend drug, or controlled substance (including Schedule I) for other than therapeutic purposes?	☐	☒
8. Have you ever been addicted to or treated for addiction to or abuse of any controlled substance, drug or chemical?	☐	☒
9. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism?	☐	☒
10. Have you ever received psychiatric therapy or treatment or received treatment for a mental illness?	☐	☒
11. Are you presently suffering from any disability or illness (mental or physical) which could affect your ability to safely practice medicine?	☐	☒

If the answer to any of questions 7 through 11 is YES, please enclose a letter giving details of your use, condition or addiction. Include the name and address of the treating professional and/or institution.

12. List any malpractice settlement, award or payment as the result of a claim or action for damages alleged to have been caused by your incompetence or negligence in the practice of medicine. Include the nature of the case, date, and summarize care given. Enclose a copy of the original complaint and of the settlement or award.	☐	☒

FAILURE TO GIVE COMPLETE AND TRUE INFORMATION CONSTITUTES CAUSE FOR DENIAL OF YOUR APPLICATION FOR LICENSURE.

PREVIOUS REGISTRATION

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

State or Other	Profession	Certificate		Permanent or Temporary	License Received By		Currently in Force
		Year	No.		Examination	Other	
WASHINGTON	MD	1983-84		TEMP		✓	YES

PROFESSIONAL TRAINING AND EXPERIENCE

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

List hospitals and local medical societies, including mailing addresses, in which you have had membership and/or privileges within the past five years. List internships and residency programs, including the city and state and any hospitals utilized in the training.

From ..... To Month, Day, Year		Name and Location of Institution, Place of Practice or Other	Degree or Certificate and Date Received, or Nature of Experience or Specialty
7/71	7/79	UNI OF ILLINOIS, URBANA	BS, BIOLOGY
7/79	6/83	UNI OF CAL. SCHOOL OF MEDICINE	MD
6/83	7/84	GHC FPR	INTERNSHIP

Applicants for licensure by STATE RECIPROCITY 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. (To be completed only if license was obtained by written examination).

I certify that the aforesaid ______________________ in h ______ examination before the ______________________

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

Subject	Percent	Subject	Percent

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

DAY I
BASIC SCIENCES ________

DAY II
CLINICAL SCIENCES ________

DAY III
CLINICAL COMPETENCE ________

I do further certify that certificate number ________________ 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 recommended 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 ____

____

SECRETARY OF THE ________________

[SEAL]

POST OFFICE ADDRESS ________________

AFFIDAVIT

I, JORGE MADEIRA DE FREITAS GARCIA, being first duly sworn, depose and say that I am the
print or type full name of applicant

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

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

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

Jorge Garcia
applicant's signature

[SEAL]

Subscribed and sworn to before me this 31st

day of April, 1984

[illegible],

Notary Public for the state of Washington

Residing at Redmond

WORKSHEET FOR MEDICAL LICENSURE APPLICATIONS

APPLICANT NAME _____ DATE OF APPL. RECEIPT _____

I.	METHOD OF LICENSURE	SCORES REC'D		
	✓ National Board Waiver	91.7		✓
	___ Flex Waiver			
	___ Reciprocity-_____			
	___ LMCC			
	___ Examination (NA. FLEX)			
II.	FEE RECEIVED	OK		
III.	PHOTOGRAPH(S) (1 for waiver/2 for exam)	OK		
IV.	APPLICATION FORM			
	Affidavit	OK		✓
	Chronology	OK		✓
	Personal Data	OK		✓
V.	SUPPORTING DOCUMENTS			
	Transcripts or MED-5 (must show subjects, degree, date)	OK		✓
	Post Graduate Training	OK		✓
VI.	FOREIGN GRADUATES			
	ECFMG Standard Certificate OR Fifth Pathway	OR		
VII.	BACKGROUND			
	States of Prior Licensure: ( )___( )___( )___( )___( )___	none		
	Hospital Priviledges: ( )_____( )_____	none		
	( )_____( )_____			
	Residency Programs: ( )[illegible]( )_____	OK		✓
	AMA Clearance MD_____		Need AMA	✓

ADMINISTRATION RECOMMENDATION: 2-4-85 ADS

FINAL ACTION: ___ Approved For Exam By_____ Date_____ BOARD REVIEW:
___ Denied for Exam By_____ Date_____
✓ Approved For Lic By ADS Date 2-22-85

GARCIA, JORGE 00022643MD-PAGE 5

AMA PHYSICIAN PROFILE -

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 01-29-85
TIME: 3:29 PM

NAME: GARCIA,JORGE MF, M.D.
ADDRESS: 200 15TH AVE E SEATTLE WA 98112
BIRTHPLACE: BRAZIL/ BIRTHDATE: 08/13/55
MEDICAL EDUCATION (SCHOOL YEAR):
UNIV OF CALIFORNIA SCH MED,SAN FRANCISCO CA 94143 1983
NATIONAL BOARD CERTIFICATION: 1984
LICENSES:
NONE REPORTED TO DATE
PHYSICIAN'S PROFESSIONAL ACTIVITIES:
RESIDENT
PRIMARY SPECIALTY: FAMILY PRACTICE
SECONDARY SPECIALTY: UNSPECIFIED
TERTIARY SPECIALTY: UNSPECIFIED
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE
MEMBER OF AMA: NOT MEMBER
NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE
PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE
CURRENT MEDICAL TRAINING: RESIDENT
HOSPITAL: GROUP HLTH COOPERATIVE SEATTLE WA 98112
DATES OF TRAINING: 07/84-06/86
SPECIALTY: FAMILY PRACTICE
SPECIALTY: UNSPECIFIED
INTERNSHIP:
HOSPITAL: GROUP HLTH COOPERATIVE SEATTLE WA 98112
DATES OF TRAINING: 07/83-06/84
SPECIALTY: FAMILY PRACTICE
SPECIALTY: UNSPECIFIED
RESIDENCY:
NONE REPORTED TO DATE
FELLOWSHIP:
NONE REPORTED TO DATE

COPYRIGHT 1985 AMERICAN MEDICAL ASSOCIATION **AMA FILES CHECKED** SEE REVERSE

AMA PHYSICIAN PROFILE (CONTINUED)

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

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Jorge Madeira De Freitas Garcia, 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 C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL

EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa.

07/02/84

Certificate # 281630

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from U CA - SAN FRANCISCO in JUNE 1983 and whose birth date is 08/13/1955. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/81		
Anatomy, incl. histology and embryology	475	79
Physiology	505	81
Biochemistry	605	87
Pathology	450	77
Microbiology, incl. immunology	485	80
Pharmacology and Materia Medica	520	82
Behavioral Sciences	615	88
TOTAL TEST (Minimum Passing Score 380/75)	530	82
Part II passed 09/82		
Internal medicine and the medical specialties	540	84
Surgery and the surgical specialties	495	82
Obstetrics and Gynecology	440	79
Public Health and Preventive Medicine	605	87
Pediatrics	450	80
Psychiatry	445	79
TOTAL TEST (Minimum Passing Score 290/75)	495	82
PART III passed 03/84		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	475	81.2
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		81.7

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Ann K. Heverling
Secretary for Certification

SEAL

05/09/84
Date

NAME GARCIA, JORGE M F

FORMER NAME

DATE ADMITTED 09-27-79

BIRTHDATE 08-13-55
BIRTHPLACE BRAZIL

M AS OF 12-14-84 01

MEDICINE
4

ADMISSION CREDENTIALS
U OF ILLINOIS CHICAGO CIRCLE BS 1979

SUBJECT A

AMERICAN HIST

AMERICAN INST

GRADUATION
MD 06-12-83

DEPARTMENT COURSE	UNITS	GRD	CODES
FALL 1979			
AMB CM MED 180	2.00	P	
ANATOMY 100A	5.00	P	
ANATOMY 102	5.00	P	
BIOCHEM 100A	5.00	P	
MEDICINE 131A	1.00	P	
PSYCHIATRY 100A	2.00	P	
UNITS COMPLETED	20.00		
WINTER 1980			
AMB CM MED 160.01	2.00	P	
ANATOMY 100B	4.00	P	
BIOCHEM 100B	5.00	P	
MEDICINE 131B	3.00	P	
PHYSIOLOGY 100	6.00	P	
PSYCHIATRY 100B	1.00	P	
UNITS COMPLETED	21.00		
SPRING 1980			
ANATOMY 103	6.00	P	
EP INTL HL 101	3.00	P	
MEDICINE 131C	2.00	P	
MICROBIOL 100A	1.50	P	
PHYSIOLOGY 101	4.00	P	
UNITS COMPLETED	16.50		
FALL 1980			
INTERDEPT 135	3.00	P	
MEDICINE 132A	8.00	P	
MICROBIOL 100B	6.50	P	
PATHOLOGY 101	4.00	P	
PEDIATRICS 100	2.00	P	
UNITS COMPLETED	23.50		
WINTER 1981			
FAM CM MED 170.02	2.00	P	
MEDICINE 132B	8.00	P	
PATHOLOGY 102	3.00	P	
PHARMACOL 100A	3.00	P	
PSYCHIATRY 131A	2.00	P	
PSYCHIATRY 180	2.00	P	
RADIOLOGY 100	2.00	P	
UNITS COMPLETED	22.00		
SPRING 1981			
EP INTL HL 100	2.00	P	
MEDICINE 132C	3.00	P	
PATHOLOGY 103	3.00	P	
PHARMACOL 100B	5.00	P	
PSYCHIATRY 131B	2.00	P	
UNITS COMPLETED	15.00		
SS 3 1981			
OB GYN R S 110	9.00	P	
PEDIATRICS 110	9.00	P	
PSYCHIATRY 135	.00	P	
PSYCHIATRY 135	.00	P	
UNITS COMPLETED	18.00		
FALL 1981			
PSYCHIATRY 135	.00	P	
RADIOLOGY 170.10	1.00	P	
SURGERY 110	12.00	P	
UNITS COMPLETED	13.00		
WINTER 1982			
MEDICINE 110	6.00	P	
NEUROLOGY 110	6.00	P	
PSYCHIATRY 110	6.00	P	
PSYCHIATRY 135	.00	P	
PSYCHIATRY 135	.00	P	
UNITS COMPLETED	18.00		
SPRING 1982			
FAM CM MED 110	6.00	P	
MEDICINE 110	6.00	P	
MEDICINE 140.28	6.00	P	
PSYCHIATRY 135	.00	P	
UNITS COMPLETED	18.00		
SUMMER 1982			
FAM CM MED 110	6.00	P	
MEDICINE 140.35	6.00	P	
RADIOLOGY 140.09	6.00	P	
UNITS COMPLETED	18.00		
FALL 1982			
ANESTHESIA 110	3.00	P	
FAM CM MED 140.40	6.00	P	
SURGERY 140			
UNITS COMPLETED	15.00		
WINTER 1983			
DERMATOL 140.01	6.00	P	
INTERDEPT 140.22	3.00	P	
PEDIATRICS 140.01B	3.00	P	
SURGERY 111	6.00	P	
UNITS COMPLETED	12.00		
SPRING 1983			
MEDICINE 140.02	6.00	P	
UNITS COMPLETED	6.00		
SUMMARY TO DATE			
UNITS COMPLETED	242.00		

RECEIVED
JAN 25 1985
DIVISION OF
PROFESSIONAL LICENSING

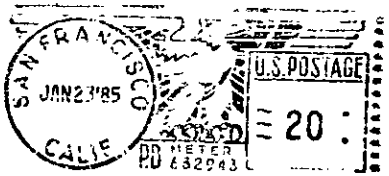
REGISTRAR

JAN 22 1985

UNIVERSITY OF CALIFORNIA
SAN FRANCISCO

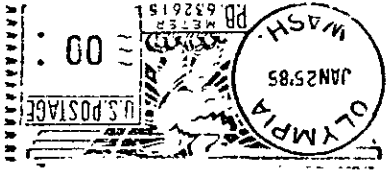
NOT OFFICIAL WITHOUT
SIGNATURE SEAL

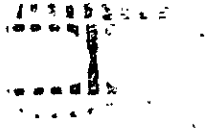
031
UNIVERSITY OF CALIFORNIA
REGISTRAR AND ADMISSIONS OFFICE
520 PARNASSUS AVENUE
SAN FRANCISCO, CALIFORNIA 94143



Division of Professional Licensing
Licensing - Medical Section
Donna Hull
P.O. Box 9649
Olympia, WA 98504

Transcript





Group Health Cooperative of Puget Sound

200 - 15th Avenue East Seattle, WA 98112 (206) 326-6736 Family Practice Residency

July 17, 1984

Department of Licensing
Division of Professional Licensing
P.O. Box 9649
Olympia, WA 98504

RE: Jorge Garcia, M.D.

Greetings;

This letter certifies that on June 30, 1984, Jorge Garcia, M.D. Successfully completed an internship year in Family Practice at Group Health Cooperative of Puget Sound Family Practice Residency.

He is continuing in the second year of our three year program until June 30, 1986. Please issue Dr. Garcia a permanent license to practice medicine for the State of Washington.

Sincerely,

Robert B. Monroe, M.D.
Program Director

RECEIVED
JUL 17 1984
DIV.
PROFESSIONAL

5352 4-14-83 40.00

LIMITED LICENSE TO PRACTICE MEDICINE

APPLICATION FOR

FEE.....$40.00

Make remittance payable to:

STATE TREASURER

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

MONEY CTL (6, 7, 8)
OFFICE USE ONLY
No. 1459
ID 6-22-83
Exp. 7-31-84
MLD. 6-23-83

Limited license application is made in conjunction with employment in: (Check one) 62 6-21

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

FOR OFFICE USE ONLY								
PROG (1)	TRANS (3)	PROF CODE (4)	GA-RC-IJ-M453NL	0 00-00-00	PIRATION DATE (9)	EXPT (10)	STAT (11)	TYPE (12)
LA		25214	GARCIA,JORGE MADEIRA					
KEY DATE (13)		CLASS (14)			GN	SPLIT	QTRD	

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME (20) GARCIA (Last) JORGE (First) MADEIRA DE FREITAS (Middle)

ADDRESS (21) c/o Group Health Cooperative Family Practice Residency 200 15th Ave E

CITY (24) SEATTLE STATE (25) WA ZIP (26) 98112 COUNTY (27) King

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

GROUP HEALTH COOPERATIVE OF PUGET SOUND

Family Practice Residency

APPLICANT'S TELEPHONE NO. (39)

(206) 326-6736

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

APPLICANT'S SOCIAL SECURITY NO. (40)

1 - DOH Licensee Social Security Nu...

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

APPLICANT'S SEX (F or M) M DATE OF BIRTH 8 (Mo.) 13 (Day) 55 (Year)

PLACE OF BIRTH RIO DE JANEIRO

MEDICAL SPECIALTY FAMILY PRACTICE

OFFICE USE ONLY
GRAD YR/SCH (48)

INSTRUCTIONS

ALL APPLICANTS

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

3-14-83

IDENTIFICATION

HEIGHT	WEIGHT
5'10"	140
COLOR OF EYES	**COLOR OF HAIR**
BROWN	BROWN

PERSONAL DATA

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

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

PROFESSIONAL TRAINING AND EXPERIENCE

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

From.....To Month, Day, Year		Name and Location of Institution, Place of Practice or Other	Degree or Certificate and Date Received, or Nature of Experience or Specialty
8·73	6·79	UNI. OF ILL. CHAMPAIGN-URBANA	B.A. IN BIOLOGY
6·79	6·83	UNI. CAL. SAN. FRAN. SCH. OF MEDICINE	M.D. IN MEDICINE

PREVIOUS LICENSURE

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

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

AFFIDAVIT

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

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

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

this 2 day of June 1983 Signature of applicant Jorge M F Garcia

L Gail Simmons

Norary Public for Seattle [Seal]

My commission expires: 3-3-85

INSTRUCTIONS FOR SUBMITTING DOCUMENTS

APPLICANTS IN A RESIDENCY PROGRAM MUST PROVIDE THE FOLLOWING DOCUMENTATION.

1. Certified copy of a diploma issued by a medical school approved by the Board of Medical Examiners. The applicant is responsible for obtaining and submitting a certified, notarized copy of the medical school dilploma. The medical school does not automatically send a copy of the diploma to this department. If the diploma is unavailable, a letter from the medical school—with the school seal—indicating the date the applicant graduated, will be accepted.
2. Verification of residency form MED 657-57. The form is to be completed by the hospital where the applicant is serving postgraduate clinical medical training. The hospital seal must be on the form.
3. Personal data, previous licensure and professional training and experience sections on the application must be complete.
4. Affidavit must be signed and notarized.

   NOTE: A LIMITED LICENSE SHALL PERMIT THE RESIDENT PHYSICIAN TO PRACTICE MEDICINE ONLY IN CONNECTION WITH HIS DUTIES AS A RESIDENT PHYSICIAN AND SHALL NOT AUTHORIZE HIM TO ENGAGE IN ANY OTHER FORM OF PRACTICE.

APPLICANTS TO BE EMPLOYED BY A STATE INSTITUTION OR CITY/COUNTY HEALTH DEPARTMENT MUST PROVIDE THE FOLLOWING DOCUMENTATION.

1. Copy of diploma issued by a medical school approved by the Board of Medical Examiners.
2. Verification of employment form, completed by the Department of Social and Health Services or by the health department where the applicant is to be employed.
3. Proof of completion of one year of postgraduate clinical medical training. Acceptable proof is a certified copy of a certificate showing one year of training, or an official letter from the hospital at which applicant did his training, giving the dates of the training. The hospital seal MUST be on this letter.
4. Certified copy of a current and valid license in another state or a Canadian province.
5. Personal data, previous licensure and professional training and experience sections on the application must be complete.
6. Two letters of recommendation from colleagues.
7. Affidavit must be signed and notarized.

FOREIGN MEDICAL SCHOOL GRADUATES

1. In addition to the above documentation, a certified copy of the applicant's ECFMG certificate must be submitted.

2. An original translation in English by a professional translating agency must be provided of all documents not written in English or Latin.

MEDICAL BOARD WORKSHEET
"LIMITED LICENSE"

NAME Jorge Madeira Garcia DATE OF RECEIPT 4-14-83

1. APPLICATION IN CONJUNCTION WITH:

a) Institutions: ☐

Name _____

State license _____

b) County-City Health Dept.: ☐

Name _____

State license _____

c) Residency: GROUP HEALTH ☒

Hospital _____ Fam pract.

2. Fee: ☒

3. PROOF OF EDUCATIONAL EXPERIENCE:

a) Medical School Diploma ☒ NR

b) Verification of employment ☒

c) Certification of postgraduate training ☐

d) ECFMG ☐

e) Chronology ☒

4. PERSONAL DATA: ☒

5. LETTERS OF RECOMMENDATION: ☐

6. AFFIDAVIT: ☒

7. STATE CLEARANCE: Mld. _____ ☐

8. AMA CLEARANCE: Mld. _____ ☐

ADMINISTRATIVE RECOMMENDATION: _____

BOARD ACTION

	LICENSE	EXAM
APPROVED	✓	
DISAPPROVED		

DATE 6-20-83

PENDING _____ REVIEWED BY _____

MED-657-58 (R/3/77)

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

OFFICE OF THE DEAN
SCHOOL OF MEDICINE

513 PARNASSUS – S-224
SAN FRANCISCO, CALIFORNIA 94143

May 31, 1983

Group Health Cooperative of Puget Sound
100-15th Avenue, East
Seattle, Washington 98112

Dear Sir/Madam:

This is to verify that Jorge Garcia has completed all requirements of the School of Medicine and will receive the degree of Doctor of Medicine on June 12, 1983.

Diplomas are not available to graduates for several months after graduation. This letter is sent as substitute verification.

Sincerely,

H. Harrison Sadler

H. Harrison Sadler, M.D.
Associate Dean

HHS/akb

JOHN SPELLMAN
Governor

JOHN GONSALEZ
Director

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

June 14, 1983

Jorge M. Garcia
c/o Group Health Cooperative
Family Practice Residency
200 15th Ave E
Seattle, Wa 98112

This is to advise that your application for limited medical license is complete for review by the Board of Medical Examiners.

However, before we can issue the license we must receive a notarized copy of your medical school diploma. Please send that document as soon as possible after your graduation. Your license will be processed and forwarded to the hospital where you will be serving your internship/ residency within a few days after we have received that document.

If we can be of further assistance, you may contact this office.

Sincerely,

Chris Robert Rose
Administrative Assistant
Medical Licensing

Diane L. Wilde
Limited License Section
Professional Licensing Division
(206) 753-2205

MED-657-62 L.L. Ack. Ltr.-III
(R/2/82) wpc

JOHN SPELLMAN
Governor

JOHN GONSALEZ
Director

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

P.O. Box 9649, Olympia, Washington 98504

This is to certify that Jorge Madeira de Freitas Garcia has been appointed as a resident* in Family Practice Service at the Family Practice Residency at Group Health Cooperative ~~Hospital~~ for the period beginning 6 (Mo) 22 (Day) 1983 (Year). The individual responsible for this resident's patient care activities will be Robert B. Monroe, M.D.

Director of Program
(Signature)
Robert B. Monroe, 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

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

BUSINESS & PROFESSIONS SYSTEM
INPUT SOURCE DOCUMENT

VIDEO OPERATOR EXCEPTION CODE

PROG. CODE (1): LA
TRANS (3): 12
PROF. CODE (4): 25214
PIC/CIC (5):
DOCUMENT EXPIRATION DATE(9) & TYPE (10):
MONEY CTL (6): 041483 (M M D D Y Y)
ITEM NO. (7): 5352
AMOUNT (8): 4000
STATUS (11): 1
TYPE (12): 0
KEY D (13): 081355 (M M D D Y Y)
CLASS (14): R
ASSN (15):
BILL (16): 4000
SIGN (42):
SPLIT (43):
QTRD (56): (M M D D Y Y)

NAME (17): GARCIA, JORGE MADEIRA

MAILING ADDRESSES (18-44-45)
1 GROUP HEALTH COOPERATIVE
2 200 15TH AVE E
3
CITY (46): SEATTLE
STATE (47): WA
ZIP (48): 98112
CNTY (49): 17

ADDITIONAL ADDRESSES (19-50-51)
1
2
3
CITY (52):
STATE (53):
ZIP (54):
CNTY (55):

RELATIONSHIP POINTER DATA
REV CODE (20):
PIC/CIC (21):
NAME (22):
DOING BUSINESS AS (23)
1-30
31-49

PHONE (25):
SSN (26):
TAX NO. (27):
EXAM DATE (28): (M M D D Y Y)
LOCATION (29):
CERT DATE (30): (M M D D Y Y)
CERT NO. (31):
VOTER DISTRICT (32):
TITLE (33):
GRAD YR/SCH (34):
LAST ISSUE DATE (35): (M M D D Y Y)
FIRST ISSUE DATE (37): (M M D D Y Y)
BOND DATE (38): (M M D D Y Y)
BOND TYPE (39):
INS. DATE (40): (M M D D Y Y)
INS. TYPE (41):

SCREEN 1 – GENERAL SYSTEM INPUT
DP-300-200 (R/12/76)
INQUIRY: PROG CODE–LZ, TRANS–81

241
6-14-83

JOHN SPELLMAN
Governor

JOHN GONSALEZ
Director

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

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

9-11-84

Dr. Garcia,

We are in receipt of your application for medical licensure in the State of Washington. As of this date, the following documents/items are necessary to complete your application.

( ) Fee $_____ in check or money order made payable to Washington State Treasurer.

( ) Transcripts showing coursework and degree awarded sent directly from school or MED-5 form directly from school.

( ) Verification of Standard ECFMG certificate directly from issuing agency.

( ) Certification from all post graduate training programs directly to this office._____
_____.

( ) Hospital letter from all hospitals where you have had privileges within the past five years. _____
_____.

( ) Verification of state licensure whether active or inactive from_____.

( ) Application form incomplete_____
_____.

( ) Other:_____
_____.

Upon receipt of the above, your application will be submitted for administrative review. Completed applications requiring special consideration will be presented to the Board of Medical Examiners at its next scheduled meeting.

Division of Professional Licensing
Licensing-Medical Section
Donna Hull
P.O. Box 9649
Olympia, WA 98504
(206) 753-2999

JOHN SPELLMAN
Governor

JOHN GONSALEZ
Director

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

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

8-30-84

Dr. Garcia,

We are in receipt of your application for medical licensure in the State of Washington. As of this date, the following documents/items are necessary to complete your application.

( ) Fee $_____ in check or money order made payable to Washington State Treasurer.

(✓) Transcripts showing coursework and degree awarded sent directly from school or MED-5 form directly from school.

( ) Verification of Standard ECFMG certificate directly from issuing agency.

( ) Certification from all post graduate training programs directly to this office._____
_____.

( ) Hospital letter from all hospitals where you have had privileges within the past five years. _____
_____.

( ) Verification of state licensure whether active or inactive from_____.

( ) Application form incomplete_____.
_____.

( ) Other:_____
_____.

Upon receipt of the above, your application will be submitted for administrative review. Completed applications requiring special consideration will be presented to the Board of Medical Examiners at its next scheduled meeting.

Division of Professional Licensing
Licensing-Medical Section
Donna Hull
P.O. Box 9649
Olympia, WA 98504
(206) 753-2999

Application File_445892_pdf-r.pdf redacted on: 5/20/2015 16:22

Redaction Summary (3 redactions)

1 Privilege / Exemption reason used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (3 instances)

Page 1, 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 12, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance