MEDICAL BOARD WORKSHEET

NAME James Fellows Newhall DATE OF RECEIPT 4-30-81

1. LICENSURE BY
   - a) National Board Waiver ☑ Nat'l
   - b) Reciprocity from _____ ☐
   - c) FLEX Waiver ☐
   - d) LMCC ☐
   - e) Examination ☐
2. FEE ☑ ~~70~~ limited
3. ADDITIONAL PHOTOGRAPH ☑
4. PROOF OF EDUCATIONAL EXPERIENCE
   - a) Medical School Diploma ☑ TRANSCRIPT
   - b) Postgraduate Medical Training ☑ Need Board
   - c) Chronology ☑
   - d) Personal Qualifications ☑
5. FOREIGN GRADUATE
   - a) ECFMG ☐
   - b) Medical School Subjects ☐
6. LETTERS OF RECOMMENDATION ☑
7. AFFIDAVIT ☑
8. STATE CLEARANCE Mld. _____ ☐ None
9. AMA CLEARANCE Mld. 5-4-81 ☑

ADMINISTRATIVE RECOMMENDATION _____

BOARD ACTION

	LICENSE	EXAM
APPROVED	✓	
DISAPPROVED		

DATE 7-13-81

PENDING _____ REVIEWED BY Chris R Rose

MED-657-24 (R 8/75)

7288 70 043081 75.00

MONEY CTL.

APPLICATION FOR (Check one) 19328 7-14-81

LICENSE TO PRACTICE

☑ MEDICINE

☐ OSTEOPATHIC MEDICINE AND SURGERY

FEES
Medicine with Exam. $175.00
Medicine w/o Exam. $150.00
Osteopathic Medicine & Surgery $150.00

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

Make remittance payable to:
STATE TREASURER

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

FOR OFFICE USE ONLY

NE-WH-AJ-F523JC 0 00-00-00
NEWHALL, JAMES FELLOWS

PROG	TRANS	PROF CODE	EXPIRATION DATE	EXPT	STAT	TYPE
LA		252				

KEY DATE	CLASS	ASSN	BILLED AMOUNT	SIGN	SPLIT	QTRD

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME NEWHALL (Last) JAMES (First) FELLOWS (Middle)

ADDRESS E 961 Ninth Ave

CITY Spokane STATE Wa ZIP 99202 COUNTY Spokane

TELEPHONE NO. (509) 534 0378
Enter the number at which you can be reached during normal business hours.

SOCIAL SECURITY NUMBER
Requested for identification purposes only. Entering SSN is voluntary and is not required for licensing approval.

1 - DOH Licensee Health Professional...

SEX (F or M) M DATE OF BIRTH April (mo.) 3 (day) 48 (yr.)

BIRTHPLACE Bangor (City) Maine (State) Penobscot (County)

MEDICAL SPECIALTY Family Medicine (Resident)

Medical/Osteopathic School University of California, Davis Year Graduated 1980

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

INSTRUCTIONS

1. 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) COPIES OF ALL DOCUMENTS MUST BE CERTIFIED AS TRUE AND NOTARIZED.
   (d) ALL APPLICATIONS MUST BE ACCOMPANIED BY APPLICABLE FEE. FEES ARE NON-REFUNDABLE.

3-5-51

APPLICANTS MUST PROVIDE THE FOLLOWING

2. CERTIFICATION
   (a) Applicants for licensure by NATIONAL BOARD WAIVER must furnish "Certification of Record" direct from the National Board of Medical Examiners, 3930 Chestnut Street, Philadelphia, Penn. 19104, OR the National Board of Examiners for Osteopathic Physicians & Surgeons, 22 S. Washington St., Park Ridge, Ill., 60068.
   (b) Applicants for licensure by FLEX WAIVER must furnish examination results direct from FLEX office, 2626- B West Freeway, Fort Worth, Texas 76102.
   (c) Applicants for licensure by L.M.C.C. must furnish certification direct from The Medical Council of Canada, 1867 Alta Vista Dr., Box 8234, Ottawa, Ontario K1G 3H7.
   (d) Applicants for licensure by STATE RECIPROCITY must have Page 4 of the application completed.

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

4. OSTEOPATHIC MEDICINE AND SURGERY ONLY
   (a) Copy of diploma issued by a legally chartered school of osteopathic medicine and surgery.
   (b) Certificate showing completion of one year of internship in any nationally accepted approved one year internship program; or the first year of a residency program approved by the American Osteopathic Association, the American Medical Association or by their recognized affiliate residency accrediting organizations.
   (c) Two (2) letters of recommendation attached to this application.
   (d) See accompanying EXCERPTS for more detailed information.

5. IN ADDITION TO the requirements listed above, graduates of U.S. and Canadian medical schools and osteopathic schools must provide official transcripts direct from their school of graduation. Transcripts will NOT be accepted from the applicant.

IDENTIFICATION

HEIGHT 6'2" (188cm)	WEIGHT 190 lbs (86kg)
COLOR OF EYES Brown	COLOR OF HAIR Brown

PERSONAL DATA

If any of the following questions are answered "Yes", full details must be furnished on a separate (8½×11 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. none

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	Medicine	Exp 7/31/81	252-14 #0001130	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.

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
Mar 67	Mar 1968	Univ of California, Berkeley	
June 72	Mar 1975	Univ of California, Berkeley	A.B in English Lit
Sep 75	June 1980	Univ of California, Davis, Sch of Med	M.D.
June 80	June 1981	Sacred Heart Med Center, Spokane Wa	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 a certificate to practice .....

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

.....

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

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

.....

[SEAL]

SECRETARY OF THE .....

POST OFFICE ADDRESS .....

AFFIDAVIT

I, JAMES F NEWHALL ..... , 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 application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentations.

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

James F Newhall .....
applicant's signature

Subscribed and sworn to before me this 24 th day of April, 19 81

Audrey E. Hart .....,

Notary Public for the state of Washington

Residing at Spokane

[SEAL]

July 23, 1981

James F. Newhall, M.D.
E. 961 9th Ave.
Spokane, WA 99202

Dr. Newhall

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

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

Sincerely

JOAN BAIRD
ADMINISTRATOR

Joanne Redmond

Mrs. Joanne Redmond
Assistant Administrator
Health Care Services
(206) 753-2205

MED 657-10
(R/3/80)

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: 05-12-81
TIME: 3:59 PM

NAME: NEWHALL,JAMES FELLOWS, M.D.
ADDRESS: SACRED HEART MED CTR-DEPT FLEX SPOKANE WA 99204
BIRTHPLACE: BANGOR,ME BIRTHDATE: 04/03/48
MEDICAL EDUCATION (SCHOOL YEAR):
UNIV OF CALIFORNIA SCH MED,DAVIS CA 95616 1980
NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE
LICENSES:
NONE REPORTED TO DATE
PHYSICIAN'S PROFESSIONAL ACTIVITIES:
INTERN
PRIMARY SPECIALTY: UNSPECIFIED
SECONDARY SPECIALTY: UNSPECIFIED
TERTIARY SPECIALTY: UNSPECIFIED
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE
MEMBER OF AMA: NOT MEMBER
NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE
PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE
CURRENT MEDICAL TRAINING: INTERN
HOSPITAL: SACRED HEART MED CTR SPOKANE WA 99204
DATES OF TRAINING: 07/80-06/81
SPECIALTY: FLEXIBLE (RESIDENTS ONLY)
SPECIALTY: UNSPECIFIED
INTERNSHIP:
NONE REPORTED TO DATE
RESIDENCY:
NONE REPORTED TO DATE

 AMA FILES CHECKED SEE REVERSE

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

James Fellows Newhall, 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: WILLIAM B. HOLDEN
Chairman of the Board

SEAL

EDITHE J. LEVIT
President of the Board

Philadelphia, Pa.
07/01/81

Cert. # 207540

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of U CALIF DAVIS SCH OF MED in JUNE 1980, whose birth date is 04/03/1948, following successful completion of all examinations required for Certification by the National Board of Medical Examiners.

The grades obtained are as follows:

		Standard* Score	Scale Score
PART I passed 06/77			
Anatomy, incl. histology and embryology		505	81
Physiology		510	81
Biochemistry		425	76
Pathology		490	80
Microbiology, incl. immunology		460	78
Pharmacology and Materia Medica		450	77
Behavioral Sciences		595	87
(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**		480	79
Part II passed 04/80			
Internal medicine and the medical specialties		345	75
Surgery and the surgical specialties		445	79
Obstetrics and Gynecology		420	78
Public Health and Preventive Medicine		575	86
Pediatrics		475	81
Psychiatry		615	88
(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**		470	81
PART III passed 03/81			
A General Test of Clinical Competence (Minimum Passing Grade 290/75)	AVERAGE	510	82.5
GENERAL AVERAGE (Parts I, II, and III)			80.8 (Scale Score)

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

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

Ann K. Heuerling
Secretary for Certification
05/11/81

SEAL

Date

THE REGENTS OF THE

University of California

ON THE NOMINATION OF THE FACULTY OF THE SCHOOL OF MEDICINE

HAVE CONFERRED UPON

JAMES FELLOWS NEWHALL

THE DEGREE OF DOCTOR OF MEDICINE

WITH ALL THE RIGHTS AND PRIVILEGES THERETO PERTAINING

GIVEN AT DAVIS THIS THIRTEENTH DAY OF JUNE IN THE YEAR

NINETEEN HUNDRED AND EIGHTY

Edmund G. Brown Jr.
GOVERNOR OF CALIFORNIA AND
PRESIDENT OF THE REGENTS

David S. Saxon
PRESIDENT OF THE UNIVERSITY

J. H. Meyer
CHANCELLOR AT DAVIS

Stanley Gold
ACTING DEAN OF THE SCHOOL

This is to certify that this is a true copy of the original document.

James F. Marshall MD

Subscribed and sworn to before me this 21st day of April 1981

Bonnie J. Evans

Notary Public in and for the State of Washington
residing in Spokane.

753315 | 63548-227 G | NEWHALL, JAMES FELLOWS | *MEDICINE | MEDICINE

FILE NUMBER | ROSTER NUMBER | NAME OF STUDENT | COLLEGE | MAJOR PROGRAM

RESIDENT | EL CERRITO, CA | BANGOR, MAINE | 04-03-48

RESIDENCE STATUS | HOME | PLACE OF BIRTH | DATE OF BIRTH

SEPT 1975

DATE ADMITTED | STUDENT STATUS

GRADUATE STUDENT RECORD CARD - | 2 - DOH Licensee Social Se... | CMC 1

UNIVERSITY OF CALIFORNIA DAVIS

05-08-80

- PREVIOUS DEGREES -

510 AB UNIV OF CALIF-BERKELEY 03-75

- MASTERS DEGREE -

- DOCTORS DEGREE -

DEGREE CONFERRED JUNE 13, 1980
DOCTOR OF MEDICINE

- CREDENTIALS/OTHER AWARDS -

LINE	DESCRIPTIVE TITLE	DEPARTMENT	COURSE NO	CREDITS	GRADE	QR PNTS	CODE
	FALL QUARTER 1975						
711	MOL & CELL BIO	MED SCI	410	6.0	S		HSU
712	ORGAN SYST BIOL	MED SCI	411A	6.0	S		HSU
713	INTRO PATIENT EVAL	MED SCI	412A	2.0	S		HSU
714	HUM DEVEL	MED SCI	413A	2.0	S		HSU
				16.0*			
	WINTER QUARTER 1976						
715	ORGAN SYST BIO	MED SCI	411B	12.0	S		HSU
716	INTRO PATIENT EVAL	MED SCI	412B	2.0	S		HSU
717	HUM DEVEL	MED SCI	413B	2.0	S		HSU
718	AUTOPSY CASE STDY	PATH	408	2.0	S		HSU
				18.0*			
	SPRING QUARTER 1976						
720	ELEC PRECEPTORSHIP	FAM PRA	401	2.0	S		HSU
721	GROUP STUDY	FAM PRA	498	3.0	S		HSU
722	ORGAN SYS BIO	MED SCI	411C	12.0	S		HSU
723	INTRO PATIENT EVAL	MED SCI	412C	2.0	S		HSU
724	FOUND COMM HEALTH	MED SCI	414	2.0	S		HSU
				21.0*			
	SUMMER QUARTER 1976						
725	METABOLIC REGUL SYS	MED SCI	S420A	5.0	S		HSU
726	PATIENT EVAL	MED SCI	S421A	3.0	S		HSU
727	PRINC PHARM	MED SCI	S423	4.0	S		HSU
728	PATHOBIOL	MED SCI	S422	6.0	S		HSU
				18.0*			
	FALL QUARTER 1976						
729	GROUP STUDY	FAM PRA	498	2.0	S		HSU
730	HEMATOPOIETIC SYST	MED SCI	420B	6.0	S		HSU
731	MUSCULOSKELETAL SYS	MED SCI	420C	4.0	S		HSU
732	CARDIOVASCULAR SYST	MED SCI	420D	6.0	S		HSU
733	PATIENT EVAL	MED SCI	421B	3.0	S		HSU
				21.0*			
	WINTER QUARTER 1977						
734	ELEC PRECEPTORSHIP	FAM PRA	401	2.0	S		HSU
735	ADV GROUP STUDY	HUM ANA	498	2.0	S		HSU
736	RESPIRATORY SYST	MED SCI	420E	6.0	S		HSU
737	NEUROSCIENCES	MED SCI	420F	7.0	S		HSU
738	INTEGUMENTARY SYST	MED SCI	420G	3.0	S		HSU
739	PATIENT EVAL	MED SCI	421C	3.0	S		HSU
740	GROUP STUDY	RAD DIA	498	2.0	S		HSU
				25.0*			
	SPRING QUARTER 1977						
741	GROUP STUDY	FAM PRA	498	3.0	S		HSU
742	URINARY SYSTEM	MED SCI	420H	6.0	S		HSU
743	GASTROINTESTINAL	MED SCI	420I	6.0	S		HSU
744	REPRODUCTIVE SYST	MED SCI	420J	4.0	S		HSU
745	PATIENT EVAL	MED SCI	421D	3.0	S		HSU
746	CASE DISCUSSIONS	NEUROL	467	3.0	S		HSU

4 1981

753315 | 63548-227 G | NEWHALL, JAMES FELLOWS | *MEDICINE | MEDICINE

FILE NUMBER | ROSTER NUMBER | NAME OF STUDENT | COLLEGE | MAJOR PROGRAM

LINE	DESCRIPTIVE TITLE	DEPARTMENT - COURSE NO	CREDITS	GRADE	GR. PNTS	CODE
			25.0*			
	SUMMER QUARTER 1977					
747	MED CLERKSHIP	MED SCI S431	18.0	U		HSU
			18.0*			
	FALL QUARTER 1977					
748	MED CLERKSHIP	MED SCI 431	18.0	S		HSU
749	PSYCHTY CLERKSHIP	MED SCI 433	9.0	S		HSU
			27.0*			
	WINTER QUARTER 1978					
750	SURG APPROACH PHYS	HUM PHY 221	2.0	S		HSU
751	SURGERY CLERKSHIP	MED SCI 430	18.0	S		HSU
			20.0*			
	SPRING QUARTER 1978					
752	MATERNAL CLERKSHIP	MED SCI 432A	9.0	S		HSU
753	CHILD HLTH CLKSHP	MED SCI 432B	9.0	S		HSU
			18.0*			
	FALL QUARTER 1978					
754	FAM PRAC CLERK	FAM PRA 469	9.0	S		HSU
			9.0*			
	WINTER QUARTER 1979					
755	RESEARCH	PSYCHTY 499	5.0	S		HSU
			5.0*			
	SUMMER QUARTER 1979					
757A	CLIN RADIODIAGNOSIS	RAD DIA S461	9.0	S		HSU
757	GEN MED CLKSHP	GEN MED S460	9.0	S		HSU
			18.0*			
	FALL QUARTER 1979					
758	OB GYN CLERKSHIP	OB&GYN 465	9.0	H		HSU
			9.0*			
	WINTER QUARTER 1980					
759	EMERG MED CLERKSHIP	EMR MED 460	9.0	S		SU
			9.0*			
	SPRING QUARTER 1979					
755A	CARDIOL CLIN CLERK	CARDIOL 460	9.0	H		HSU
			9.0*			

- MEMORANDA -

06-69 ACADEMIC SENATE RULING EXCLUDES E & I GRADES FROM GPA

LINE	DESCRIPTIVE TITLE	DEPARTMENT - COURSE NO.	CREDITS	GRADE	GR. PNTS.	CODE
950	SU MED SCI 413A-B I GD CHG V PET 7-20-76					
951	SU MED SCI 412A I GD CHG V PET 9-13-76					
952	SU MED SCI 412B I GD CHG V PET 9-13-76					
953	SU MED SCI 412C I GD CHG V PET 9-13-76					
954	SU MED SCI 5422 I GD CHG V PET 06-28-77					
955	SU-MED SCI 431 I GD CHG V PET 08-15-78					

04-22-80 ALLOWED TO RETROACTIVELY ADD RAD DIA S461 SUMMER QTR 1979 9 UN V PET

06-09-80 SU: EMR MED 460 E/I GRD CHG V PETN

12-18-79 ALLOWED TO RETROACTIVELY ADD CARDIOL 460 SPRING QTR 1979 V PET

QUARTER CREDITS COMPLETED 268.0

TRANSCRIPT OF RECORD 1-7-81 (I)

END OF RECORD

S 3410 11-73
H 9204

UNIVERSITY OF CALIFORNIA

NOTICE CONCERNING TRANSCRIPT OF RECORD

At the request of

James Fellows Newhall
E961 - 9th Avenue
Spokane, WA 99202

we are forwarding to the address given below a transcript of this student record in the University of California at Davis.

REMARKS:

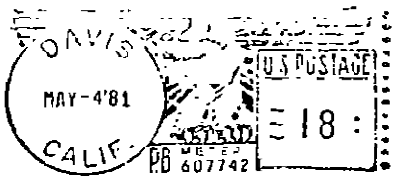
Davis, California

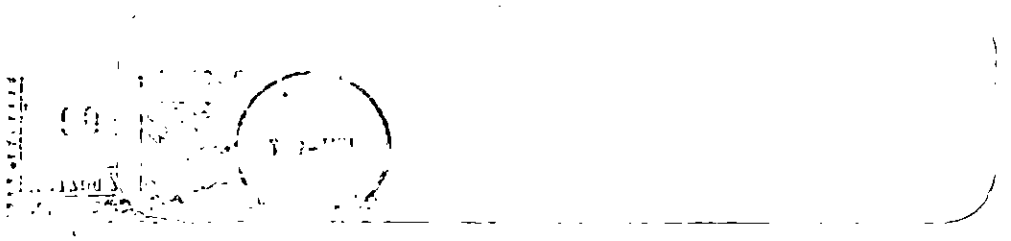
Date May 4, 19 81 Per nlm Deputy

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

UNIVERSITY OF CALIFORNIA
OFFICE OF THE REGISTRAR
DAVIS, CALIFORNIA 95616

0065





Sacred Heart Medical Center

Sisters of Providence — Spokane, Washington

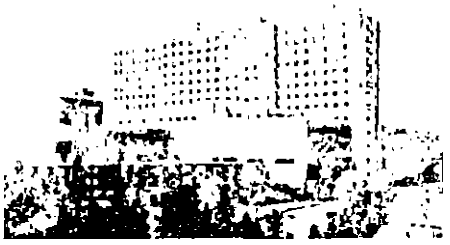
This certifies that **James Fellows Newhall, M.D.**
has satisfactorily fulfilled the duties of Resident Physician
in the Flexible service at Sacred Heart Medical Center
for a period of one year beginning 23 June 1980 and
ending 22 June 1981 and is hereby granted this Certificate in
acknowledgment of services loyally performed with all rights
and privileges thereunto appertaining

DATED June 22, 1981

Laurence G. Schuck MD
DIRECTOR OF MEDICAL EDUCATION

PRESIDENT OF THE STAFF

Sister Peter Claver S.P. MHA.
ADMINISTRATOR



SHMC
SACRED HEART MEDICAL CENTER
W. 101 EIGHTH AVE. TAF-C9 SPOKANE, WASHINGTON 99220 (509) 455-3131

June 30, 1981

Chris Robert Rose
Administrative Assistant
Medical Section
Washington State Professional Licensing Division
P.O. Box 9649
Olympia, WA 98504

Dear Mr. Rose

RE: Licensure for Resident with Limited License

I am returning this letter from Dr. Lawrence Schrock along with the certificates of completion of the internship year 1980-81.

I do appreciate the fact that you are willing to accept these un-notarized copies for the licensure applications this year. We will, in the future be sure to have each individual Resident send in a notarized copy of their certificate on the date of completion.

Thank you for understanding our situation.

Sincerely,

Sue Schafer

Sue Schafer, Sec.
Medical Education

SS/ss

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have Known JAMES FELLOWS NEWHALL for 2 years, from 1979 to 81 during which period he was engaged in the study or active practice of medicine. To the best of my knowledge he is of good moral and professional character, is free from habits which might interfere with h__ professional activities and is worthy of holding a license to practice Medicine & Surgery in the State of Washington.

PLEASE PRINT OR TYPE

Name Dennis L. Peterson

Title Resident Physician - Internal Medicine

Capacity in which applicant known _____

_____

Address W1625 10th Ave #2

Licensed under laws of Washington

To practice Medicine / Surgery #17752

Please comment on applicant's professional character and ethics:

_____

_____

_____

_____

_____

Signature

MED 657-12 LTR OF RECOMMENDATION
(R/10/17/80)

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have Known JAMES FELLOWS NEWHALL for 6 years, from 1975 to 1981 during which period he was engaged in the study or active practice of medicine. To the best of my knowledge he is of good moral and professional character, is free from habits which might interfere with his professional activities and is worthy of holding a license to practice Medicine in the State of Washington.

PLEASE PRINT OR TYPE

Name Elizabeth Pirruccello Newhall M.D.

Title M.D.

Capacity in which applicant known medical student; intern

Address E. 961 9th Ave Spokane, WA 99202

Licensed under laws of WASHINGTON & IDAHO

To practice WASHINGTON-medicine / IDAHO-medicine & surgery

Please comment on applicant's professional character and ethics:

Jim is an outstanding physician and a pleasure to work with. I have always been impressed with his knowledge and ability; there is no question concerning his ethics in medical practice.

Elizabeth Newhall MD
Signature

MED 657-12 LTR OF RECOMMENDATION
(R/10/17/80)

PO Box 9649
Olympia 98504

The following documentation in support of my application for licensure has been requested:

Certification of National Board
Transcript from Univ of Calif. Davis
Certification of Completion of Internship from Sacred Heart Medical Center, Spokane WA.
June 23 1981

Please let me know if they are deluged

James F Newhall

JOHN SPELLMAN
Governor

JOHN GONSALEZ
Director

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

May 4, 1981

P.O. Box 9649, Olympia, Washington 98504

James Fellows Newhall M.D.
E. 961 Ninth Ave.
Spokane, WA 99202

Dr. Newhall:

Thank you for your medical application received in this office 4-30-81. The next meeting of the Board will be held on July 10-11, 1981 at which time your application will be reviewed, if complete. You will be advised of board decision approximately two weeks after the board meeting.

Application appears complete ( )

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

Lacks the following ( )

Postgraduate Training
Medical School Diploma
Medical School Subjects (MED-5)
Original E.C.F.M.G. Certificate
Other **Official transcripts from Medical school.**

Copies of all documents must be certified as true.

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

Remarks: **Notarized certificate of postgraduate training.**

Sincerely

Medical Section
Professional Licensing Division
(206) 753-2205

MED 657-14
(R/3/80)

APPLICATION FOR #11301 ✓ 6429

LIMITED LICENSE TO PRACTICE MEDICINE

W-6429 | 70 060200 | 40.00 | MONEY CTL

ID 6-23-80

FEE **$40.00**
(Includes $25.00 application fee and $15.00 License Issuance fee.)

EX 7-31-81

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

Make remittance payable to:
STATE TREASURER

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

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

FOR OFFICE USE ONLY

PROG	TRANS	PROF CODE	PIC/CIC		EXPIRATION DATE	EXPT	STAT	TYPE
LA		25214	NE-WH-AJ-F523JC	0 00-00-00				
KEY DATE		CLASS	NEWHALL, JAMES FELLOWS		SIGN	SPLIT	QTRD	

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME Newhall (Last) James (First) Fellows (Middle)

ADDRESS E 961 Ninth Ave

CITY Spokane STATE WA ZIP 99202 COUNTY Spokane

EMPLOYER'S NAME (DBA) Sacred Heart Medical Center

APPLICANT'S TELEPHONE NO. 534-0378
Enter the number at which you can be reached during normal business hours.

APPLICANT'S SOCIAL SECURITY NO. 2 - DOH Licensee Social Security Numb...
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 Apr 3 48 (mo. day yr.)

PLACE OF BIRTH Bangor, Maine

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

OFFICE USE ONLY
GRAD YR/SCH ____

MEDICAL SPECIALTY general medicine

APPLICANT'S RESIDENCE ADDRESS E 961 Ninth Ave

CITY Spokane STATE Wa ZIP 99202 COUNTY Spokane

INSTRUCTIONS

1. This application, together with supporting documents and fee should be filed with the Division of Professional Licensing not later than forty-five (45) days prior to the Board meeting at which it is to be reviewed.
2. If additional space is required, attach separate (8½ x 11 inch) sheets, indicating the section to which they refer.
3. Attach a certified copy of Medical School diploma.
4. Attach a certified copy of one year of postgraduate training. (If appropriate)
5. Attach a certification of licensure status from another state (If appropriate)
6. If a foreign medical graduate, attach evidence of completion of E.C.F.M.G.
7. Two (2) Letters of recommendation attached to this application.

RECEIVED
JUN 2 1980
DIVISION OF PROFESSIONAL LICENSING

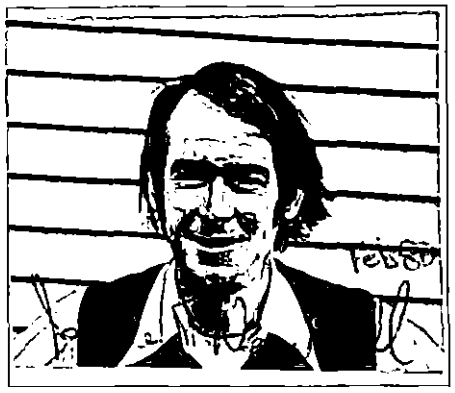
COPIES OF ALL DOCUMENTS MUST BE CERTIFIED AS TRUE AND NOTARIZED. FEE MUST ACCOMPANY APPLICATION.

med 4-15-80

MED-657-056 Ltd. Lic. App. (R/3/77)

IDENTIFICATION

HEIGHT	WEIGHT
6' 2"	185
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 the Controlled Substance Act, or any 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 narcotic drugs?	☐	☒
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?	☐	☒

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	

PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience including college, university, military, technical or professional school and practice pertaining to the profession for which you are making application. Include 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 Month, Day, Year	To	Name and Location of Institution, Place of Practice or Other	Degree or Certificate and Date Received, or Nature of Experience or Specialty
Sept 75	June 80	Univ of Calif, Davis 95616	MD June '80
June 72	Mar 75	Univ of Calif, Berkeley	B.A Mar 75

AFFIDAVIT

I, JAMES FELLOWS NEWHALL, 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 accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

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

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penaly 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 30th day of April 19 80 Signature of applicant James F Newhall

[Seal]

Notary Public for Audrey L. Hart

My commission expires: January 5, 1984

MEDICAL BOARD WORKSHEET
"LIMITED LICENSE"

NAME NEWHALL, James Fellows DATE OF RECEIPT 6-2-80

1. APPLICATION IN CONJUNCTION WITH:

a) Institutions: ☐

Name

State license

b) County-City Health Dept.: ☐

Name

State license

c) Residency: ☒

Hospital Sacred Heart

2. Fee: ☒ 6-2-80

3. PROOF OF EDUCATIONAL EXPERIENCE:

a) Medical School Diploma ☒ Rec'd 8-4-80

b) Verification of employment ☒ 6-2-80

c) Certification of postgraduate training ☐

d) ECFMG ☐

e) Chronology ☒ 6-2-80

4. PERSONAL DATA: ☒ 6-2-80

5. LETTERS OF RECOMMENDATION: ☒ 6-2-80

6. AFFIDAVIT: ☒ 6-2-80

7. STATE CLEARANCE: Mld. ☐

8. AMA CLEARANCE: Mld. ☐

ADMINISTRATIVE RECOMMENDATION:

BOARD ACTION

	LICENSE	EXAM
APPROVED	✓	
DISAPPROVED		

DATE 6-12-80

PENDING 3-IX REVIEWED BY

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

THE REGENTS OF THE

University of California

ON THE NOMINATION OF THE FACULTY OF THE SCHOOL OF MEDICINE
HAVE CONFERRED UPON

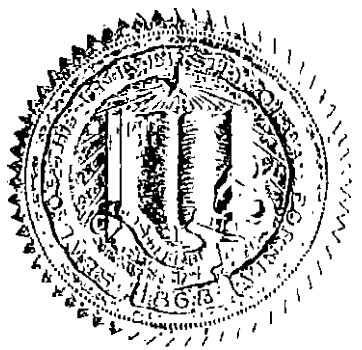
JAMES FELLOWS NEWHALL

THE DEGREE OF DOCTOR OF MEDICINE
WITH ALL THE RIGHTS AND PRIVILEGES THERETO PERTAINING

GIVEN AT DAVIS THIS THIRTEENTH DAY OF JUNE IN THE YEAR
NINETEEN HUNDRED AND EIGHTY

Edmund G. Brown Jr.
GOVERNOR OF CALIFORNIA AND
PRESIDENT OF THE REGENTS

David S. Saxon
PRESIDENT OF THE UNIVERSITY



J. H. Meyer
CHANCELLOR AT DAVIS

Walter A. Gold
ACTING DEAN OF THE SCHOOL

THIS IS TO CERTIFY THAT THIS IS A TRUE COPY OF THE ORIGINAL DOCUMENT.

James F. Newhall

SUBSCRIBED AND SWORN TO BEFORE ME THIS 28 DAY OF July 1980

Don S. Rupp

NOTARY PUBLIC IN AND FOR THE
STATE OF WASHINGTON, RESIDING IN
SPOKANE

UNIVERSITY OF CALIFORNIA, DAVIS

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

SANTA BARBARA • SANTA CRUZ

OFFICE OF STUDENT AFFAIRS
ADMISSIONS OFFICE

SCHOOL OF MEDICINE
DAVIS, CALIFORNIA 95616

May 8, 1980

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

Dear Sir:

This is to certify that JAMES FELLOWS NEWHALL is a full time registered student in good standing at the University of California, Davis, School of Medicine and will complete all requirements for the M.D. Degree by the end of Spring Quarter, 1980. He will receive his M.D. Degree on June 20, 1980.

Ernest M. Gold, M.D.
Acting Dean
School of Medicine

EMG/lrd

STATE OF WASHINGTON

Dixy Lee Ray
Governor

DEPARTMENT OF LICENSING
P.O. Box 9649, Olympia, Washington 98504

This is to certify that JAMES F. NEWHALL, M.D. has been appointed as a resident* in FLEXIBLE INTERNSHIP at the SACRED HEART MEDICAL CENTER Service hospital for the period beginning JUNE 23, 1980 (Mo Day Yr). The individual responsible for this resident's patient care activities will be Raymond L. Lowenberg, Jr. (Signature), Director of Program.

*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)

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have known James Fellows Newhall

for one years; from June 1979 to June 1980

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

Signature [signature]

Address E 1022 Thurston Spokane Wa

Licensed under laws of State of Washington

To practice Medicine

MED-657-12 Letter of Recommendation
(R/[illegible]/77)

LETTER OF RECOMMENDATION

DIVISION OF PROFESSIONAL LICENSING
STATE OF WASHINGTON

This is to certify that I have known James Fellows Newhall

for 1 years, from 1979 to 1980

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

Signature [signature], M.D

Address E 2407 8th Ave Spokane Wa

Licensed under laws of Washington, License #0017752

To practice Medicine / Surgery

MED-657-12 Letter of Recommendation
(Rev. 7/77)

STATE OF
WASHINGTON

Dixy Lee Ray
Governor

DEPARTMENT OF LICENSING
P.O. Box 9649, Olympia, Washington 98504

June 11, 1980

James Fellows Newhall
E 961 Ninth Ave.
Spokane, WA 99202

Dear Mr. Newhall

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,

(Mrs.) Joanne Redmond
Assistant Administrator
Health Care Services

Arlene Robertson
Limited License Section
Professional Licensing Division
(206) 753-2205

MED-657-62 L.L. Ack. Ltr.-III
(N/2/80) wpc

BUSINESS & PROFESSIONS SYSTEM
INPUT SOURCE DOCUMENT

VIDEO OPERATOR EXCEPTION CODE

PROG. CODE (1): LA
TRANS (3): 12
PROF. CODE (4): 252114
PIC/CIC (5):
MONEY CTL (6): 060280 (M M D D Y Y)
ITEM NO. (7): 6429
AMOUNT (8): 4000
DOCUMENT EXPIRATION DATE(9) & TYPE (10): (M M D D Y Y)
STATUS (11): 1
TYPE (12): 0
KEY D (13): 040348 (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): NEWHALL, JAMES FELLOWS

MAILING ADDRESSES (18-44-45)
1 SACRED HEART MEDCTR
2 MEDICAL EDUCATION
3 WEST 101 EIGHTH AVE
CITY (46): SPOKANE
STATE (47): WA
ZIP (48): 992014
CNTY (49): 32

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: SACRED HEART MEDCTR
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 INQUIRY: PROG CODE–LZ, TRANS–81
DP-300-200 (R3/02/78)

702
6-6-80

29 July 80
E 961 4th Avenue
Spokane WA 99202

Ladies & Gentlemen,

The enclosed documentation is submitted in support of my application for limited licensure as a resident physician. My application should now be complete; please notify me of any deficiencies.

Sincerely.
James T Newhall MD

BUSINESS & PROFESSIONS SYSTEM
INPUT SOURCE DOCUMENT

VIDEO OPERATOR EXCEPTION CODE

PROG. CODE (1): LA | TRANS (3): 14 | PROF. CODE (4): 25209

PIC/CIC (5):

DOCUMENT EXPIRATION DATE(9) & TYPE (10): M M D D Y Y

MONEY CTL (6): 043081 (M M D D Y Y) | ITEM NO. (7): 7288 | AMOUNT (8): 75.00

STATUS (11): 1 | TYPE (12): 0 | KEY D (13): 040348 (M M D D Y Y) | CLASS (14): | ASSN (15):

BILL (16): 7500 | SIGN (42): | SPLIT (43): | QTRD (56): M M D D Y Y

NAME (17): NEWHALL, JAMES FELLOWS

MAILING ADDRESSES (18-44-45)

1: E 9611 9TH AVE
2:
3:

CITY (46): SPOKANE | STATE (47): WA | ZIP (48): 99202 | CNTY (49): 32

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): 5 | TITLE (33): | GRAD YR/SCH (34): 00410 | 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 INQUIRY: PROG CODE–LZ, TRANS–B1
DP-300-200 (R/12/76)

121 5-1-81

Application File_511599_pdf-r.pdf redacted on: 5/11/2015 10:23

Redaction Summary (3 redactions)

2 Privilege / Exemption reasons used:

1 -- "DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2)" (1 instance)

2 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (2 instances)

Page 2, DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2), 1 instance
Page 12, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 23, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance