Verification of Licensure
SUBJECT TO TERMS AND CONDITIONS
Information current as of: 07/20/2015
Session: 2015-07-20 02:05:29.963 | 172.21.5.137 /0rz5dlf0qri4hnaivivgq0qo

This site is a primary source for verification of license credentials consistent with Joint Commission and NCQA standards.

Burkett, Donna Lynn MD

Gender: Female
Year of Birth: 1968

| Address Type | City | County | State | Phone |
|---|---|---|---|---|
| Practice | Asheville | Buncombe | North Carolina | 828-255-8900 |

License

Number: MD20096
License Type: MD License
Originally Issued: 10/18/1996
Current Status: Surrendered
Status Effective: 12/31/2001
Expedited
Endorsement: No
Basis: USMLE
Specialty: Family Practice

*Specialty is self-reported by the licensee. It does not necessarily indicate specialty board certification. Check directly with the Specialty Member Board for current certification status.*

Other Licenses

| License Number | Effective Date | Expiration Date | License Type |
|---|---|---|---|
| LL06837 | 07/01/1996 | 06/30/1997 | MD Postgraduate License |

Education

Medical School

| School Name | Location | Graduation |
|---|---|---|
| U/NC SCH/MED | CHAPEL HILL, NC United States | 05/14/1995 |

Post-Graduate

| Type | School name | Location | From | To | Specialty |
|---|---|---|---|---|---|
| Residency | OHSU | PORTLAND, OR United States | 07/1996 | | Family Practice |
| Internship | OHSU | PORTLAND, OR United States | 07/1995 | 06/1996 | Family Practice |

*The licensee may have completed additional education or training programs. Only those that have been verified with the primary source are shown.*

Board Orders

There are no public orders on file for this Licensee.

Malpractice

Oregon
John A. Kitzhaber, M.D., Governor

Board of Medical Examiners
1500 SW 1st Ave Ste 620
Portland, OR 97201-5826
(503) 229-5770
FAX (503) 229-6543
www.bme.state.or.us

JAN 7 2002

November 21, 2001

License #**MD20096**
MRP

BURKETT, DONNA LYNN, MD
PO BOX 489
ASHEVILLE, NC 28802

Dear Doctor:

The Oregon Board of Medical Examiners has received notice that you choose to surrender your Oregon medical license. In order to complete your surrender and prevent your license from lapsing, your formal license (8½ x 11 on parchment) must be returned to this office no later than **DECEMBER 5, 2001**.

Once your surrender has been completed, should you wish to practice in Oregon at a later date, you must apply as if you had never held an Oregon license and meet all requirements for licensure that are in effect at the time you apply.

If you have any questions, please call 503-229-5770 and ask for the registration department.

Sincerely,

Kathleen Haley
Executive Director

Margaret Peeples
Registration Assistant

KH:MRP

**OREGON BOARD OF MEDICAL EXAMINERS**
1500 SW 1st Ave., Suite 620
Portland, OR 97201-5826
(503) 229-5770 (Ask for Registration Dept.)

# MD/DO/LICENSE RENEWAL 2002-2003

*Payment Due by December 1, 2001 – License Will Lapse on January 1, 2002*

**IMPORTANT:** Please read Instructions before completing application. All numbered items must be verified or completed and the form signed on the last page, or it will be returned for completion, which will DELAY registration. **Mailing & practice addresses are available to the public.**

**1. NAME AND CURRENT MAILING ADDRESS**

BURKETT, DONNA LYNN, MD
PO BOX 489
ASHEVILLE, NC 28802

(O)

**2. OREGON LICENSE NO.** MD20096

**3. CURRENT STATUS** INACTIVE

**4. FEES & STATUS REQUESTED**
PAYMENT BY CHECK OR CHARGE - SEE PAGE 4.

- ☐ ACTIVE ..... $438.00
- ☐ LOCUM TENENS ..... $438.00
- ☐ INACTIVE ..... $438.00
- ☐ EMERITUS ..... $112.00
- ☐ RETIRED ..... No Fee
- ☐ ACTIVE (1 YEAR) ..... $219.00
  (you must be currently in a postgraduate training program in Oregon to register Active 1 year)

IS THE MAILING ADDRESS ABOVE CORRECT? ☐ YES ☑ NO
If NO, please provide correct mailing address below, including PO Box & PMB addresses.

WNC OB-Gyn and Family Practice
16 McDowell St.
Asheville, NC 28801

**Please read instructions before checking below.**
I do not wish to renew the registration of my license.
- ☑ I wish to surrender my license
- ☐ I wish to let my license lapse

**5. DATE OF BIRTH** /68

**6. SOCIAL SECURITY NO.**

**7. OREGON PRACTICE COUNTY** NONE/UNKNOWN

**8. SPECIALTY** FAMILY PRACTICE

**9. AMERICAN BOARD CERTIFIED IN THIS SPECIALTY?** YES

**10. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, LIST ADDRESS & TELEPHONE NUMBER OF FORMER OREGON PATIENTS' RECORDS.**
5279 NE LOMBARD ST PORT 503-285-7953;PROVIDENCE FAM PRACT NORTH PDX

**11. PRIMARY PRACTICE ADDRESS & PHONE NO. ON FILE WITH THE BOARD. IS THIS ADDRESS CORRECT?** ☐ YES ☑ NO

NONE

PROVIDE CURRENT PRIMARY PRACTICE ADDRESS & PHONE NO. BELOW. (NO PO BOX OR PMB ADDRESSES)

WNC OB-Gyn and Family Practice
16 McDowell St.
Asheville, NC 28801

(828) 255-8900

**12. RESIDENCE ADDRESS ON FILE WITH THE BOARD. IS THIS ADDRESS CORRECT?** ☐ YES ☑ NO

PROVIDE CURRENT RESIDENCE ADDRESS BELOW. (NO PO BOX OR PMB ADDRESSES)

**STAFF USE ONLY**

| L | N | O | A | P | F | S | R | Opt | Tele / Border | Disp. | Web Adrs | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Y N | Y N | |

MBP DEC 18 2001



001352 (RB-2003)

13. CHECK ALL OREGON HOSPITALS WHERE YOU HAVE STAFF PRIVILEGES. (Active or Locum Tenens physicians only.)

- ☐ Adventist Med Ctr, Portland
- ☐ Albany Gen Hsp, Albany
- ☐ Ashland Comm Hsp, Ashland
- ☐ Bay Area Hsp, Coos Bay
- ☐ BHC Pacific Gateway Hsp, Gresham
- ☐ BHC Pacific View RTC, Gresham
- ☐ Blue Mountain Hsp, John Day
- ☐ Central Oregon Community Hsp, Redmond
- ☐ Columbia Memorial Hsp, Astoria
- ☐ Coquille Valley Hsp, Coquille
- ☐ Cottage Grove Healthcare Comm, Cottage Grove
- ☐ Curry Gen Hsp, Gold Beach
- ☐ Doernbecher Children's Hsp, Portland
- ☐ Eastmoreland Hsp, Portland
- ☐ Eastern Oregon Psychiatric Ctr, Pendleton
- ☐ Good Samaritan Hsp, Corvallis
- ☐ Good Shepherd Med Ctr, Hermiston
- ☐ Grande Ronde Hsp, La Grande
- ☐ Harney District Hsp, Burns
- ☐ Holy Rosary Med Ctr, Ontario
- ☐ Kaiser Sunnyside Med Ctr, Clackamas
- ☐ Lake District Hsp, Lakeview
- ☐ Lane Co Psychiatric Hsp, Eugene
- ☐ Lebanon Comm Hsp, Lebanon
- ☐ Legacy Emanuel Hsp & Health Ctr, Portland
- ☐ Legacy Good Samaritan Hsp & Med Ctr, Portland
- ☐ Legacy Meridian Park Hsp, Tualatin
- ☐ Legacy Mt Hood Med Ctr, Gresham
- ☐ Lower Umpqua Hsp, Reedsport
- ☐ McKenzie-Willamette Hsp, Springfield
- ☐ Mercy Med Ctr, Roseburg
- ☐ Merle West Med Ctr, Klamath Falls
- ☐ Mid-Columbia Med Ctr, The Dalles
- ☐ Mountain View Hsp, Madras
- ☐ Oregon State Hsp, Salem
- ☐ OHSU Hsp, Portland
- ☐ Pacific Comm Health District, Newport
- ☐ Peace Harbor Hsp, Florence
- ☐ Pioneer Mem Hsp, Heppner
- ☐ Pioneer Mem Hsp, Prineville
- ☐ Providence Hood River Mem Hsp, Hood River
- ☐ Providence Medford Med Ctr, Medford
- ☐ Providence Milwaukie Hsp, Milwaukie
- ☐ Providence Newberg Hsp, Newberg
- ☐ Providence Portland Med Ctr, Portland
- ☐ Providence Seaside Hsp, Seaside
- ☐ Providence St Vincent Med Ctr, Portland
- ☐ Rogue Valley Med Ctr, Medford
- ☐ Sacred Heart Med Ctr, Eugene
- ☐ Salem Hsp, Salem
- ☐ Samaritan North Lincoln Hsp, Lincoln City
- ☐ Santiam Mem Hsp, Stayton
- ☐ Shriners Hsp for Children, Portland
- ☐ Silverton Hsp, Silverton
- ☐ Southern Coos Hsp & Health Ctr, Bandon
- ☐ St Anthony Hsp, Pendleton
- ☐ St Charles Med Ctr, Bend
- ☐ St Elizabeth Health Services, Baker City
- ☐ Three Rivers Comm Hsp & Health Ctr, Grants Pass
- ☐ Tillamook County Gen Hsp, Tillamook
- ☐ Tuality Healthcare, Hillsboro
- ☐ Valley Community Hsp, Dallas
- ☐ Veterans Affairs Med Ctr (VAMC), Portland
- ☐ VA Roseburg Healthcare System, Roseburg
- ☐ Wallowa Mem Hsp, Enterprise
- ☐ Willamette Falls Hsp, Oregon City
- ☐ Willamette Valley Med Ctr, McMinnville
- ☐ Woodland Park Hsp, Portland

☐ OTHER_____

14. CHECK ALL STATES WHERE YOU ARE CURRENTLY LICENSED:

- ☐ Alabama
- ☐ Alaska
- ☐ American Samoa
- ☐ Arizona
- ☐ Arkansas
- ☐ California
- ☐ Colorado
- ☐ Connecticut
- ☐ Delaware
- ☐ District of Columbia
- ☐ Florida
- ☐ Georgia
- ☐ Guam
- ☐ Hawaii
- ☐ Idaho
- ☐ Illinois
- ☐ Indiana
- ☐ Iowa
- ☐ Kansas
- ☐ Kentucky
- ☐ Louisiana
- ☐ Maine
- ☐ Maryland
- ☐ Massachusetts
- ☐ Michigan
- ☐ Minnesota
- ☐ Mississippi
- ☐ Missouri
- ☐ Montana
- ☐ Nebraska
- ☐ Nevada
- ☐ New Hampshire
- ☐ New Jersey
- ☐ New Mexico
- ☐ New York
- ☑ North Carolina
- ☐ North Dakota
- ☐ Ohio
- ☐ Oklahoma
- ☑ Oregon
- ☐ Pennsylvania
- ☐ Puerto Rico
- ☐ Rhode Island
- ☐ South Carolina
- ☐ South Dakota
- ☐ Tennessee
- ☐ Texas
- ☐ Utah
- ☐ Vermont
- ☐ Virginia
- ☐ Virgin Islands
- ☐ Washington
- ☐ West Virginia
- ☐ Wisconsin
- ☐ Wyoming

## LICENSE RENEWAL QUESTIONNAIRE

Answer all questions in both Category I and II. Category I will help the Board determine if you meet the essential eligibility requirements for license renewal. Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification.

**If you answer "yes" to questions 3-16, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results, along with your returned application.**

**NOTE:** Fraud or misrepresentation in applying for or procuring a license, registration or reactivation in Oregon are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations.

### Category I

### DURING THE PERIOD OF 1/1/00 TO THE PRESENT

1. Do you dispense drugs to your patients? Dispensing does **not** include the administration of a drug to a patient in the physician's office, nor does it include sample drugs. A dispensing physician is defined as one who purchases prescription drugs for the purpose of giving or selling them to patients or other individuals entitled to receive them.
2. Do you want your practice address posted on the Board of Medical Examiners' Web site?
3. Do you hold any licenses to practice another health care profession?
4. Have you failed a state or national examination to qualify for a state license to practice in a health care profession?
5. Has any state licensing board refused to issue, refused to renew, or denied you a license to practice?
6. Have you been asked to make a written or verbal response to an inquiry or investigation about you or your medical practice by this or any other licensing board?
7. Have you received any correspondence or notice from a licensing board or government agency relative to an inquiry or question regarding your medical practice?
8. Has any licensing board taken any disciplinary action or other formal action against you, including but not limited to, revoking, suspending, limiting or restricting your license, or reprimanding you or placing you on probation?
9. Have you been denied approval to prescribe controlled substances, or been charged with a violation of federal or state narcotic laws, or been asked to surrender your DEA number?
10. Have you been convicted of a felony or misdemeanor?
11. To your knowledge, are you currently the subject of any criminal or civil investigation?
12. Have any charges of malpractice been brought against you?
13. Have you been restricted, suspended, terminated, requested to voluntarily resign, placed on probation or been subject to formal disciplinary action during medical school and/or postgraduate training?
14. Have you interrupted the practice of your health care profession for one year or more?
15. Have you had privileges denied, reduced, restricted, suspended, revoked or terminated, or have you been placed on probation or been subject to staff disciplinary action, or requested to voluntarily resign or been subject to non-renewal of employment contracts from a hospital, clinic, surgical center, or other medically related employment while under investigation?
16. Have you ceased the active practice of medicine in your specialty?

**Use the space below to make the required written explanation concerning any affirmative responses to Category I questions 3-16. Include dates, names, addresses, circumstances, and results. Attach an additional page, if needed, with your name and date on the top.**

## Category II

The answers to Category II questions are exempt from public disclosure under ORS 192.505(2), the Oregon Public Records Law, unless a party seeking disclosure, by clear and convincing evidence, shows that disclosure would not be an unreasonable invasion of privacy and that the public interest requires disclosure in the particular instance. The answers to these questions may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

If applicable, these questions should be read to include the clause, "Other than what is known already to the Oregon Diversion Program for Health Professionals . . ."

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed health care professional who prescribed the controlled substance or dangerous drug.

### DURING THE PERIOD OF 1/1/00 TO THE PRESENT

1. Have you had, or do you currently have, any physical, mental, or emotional condition which impaired, or does impair, your ability to practice your health care profession safely and competently?
2. Have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition?
3. Have you had, or do you currently have, a dependency on the use of alcohol or drugs which impaired, or does impair, your ability to practice your health care profession safely and competently?
4. Have you engaged in the excessive or habitual use of alcohol or illegal drugs, or received any in-patient therapy/treatment or been hospitalized for alcoholism, or illegal drug use, or been arrested for a DUII (Driving Under the Influence of Intoxicants) or DWI (Driving While Intoxicated)?
5. Have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .08% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)

**Use the space below to make the required written explanation concerning any affirmative responses to Category II questions. Include dates, names, addresses, circumstances, and results. Attach an additional page, if needed, with your name and date on the top.**

☐ Payment Enclosed ☐ Charge My Credit Card $_____ Amount

Credit Card Number - VISA, MASTERCARD, OR DISCOVER

Expiration Date

Office Use Only:

Approval Date

Approval Code

Telephone Sale? ☐ Yes

Printed name as it appears on credit card

Signature

Cardholder's Billing Address

I certify that the information submitted by me is true, accurate, and complete to the best of my knowledge. I understand that failure to answer the questions fully and correctly may be grounds for disciplinary action by the Board (ORS 677.205).

Physician's Signature _____ Date 9-27-01

*(Signature stamps or proxy NOT acceptable)*

Oregon BOARD OF MEDICAL EXAMINERS
620 Crown Plaza
1500 SW First Avenue
Portland, OR 97201-5826

PORTLAND OR

U.S. POSTAGE 03.56 H METER

BG
DEC 11 2001
NOT DELIVERABLE AS ADDRESSED, UNABLE TO FORWARD

IMPORTANT! DO NOT DESTROY! OPEN AND REVIEW IMMEDIATELY

BURKETT, DONNA LYNN, MD
PO BOX 489
ASHEVILLE, NC 28802

A ☐ INSUFFICIENT ADDRESS
C ☐ ATTEMPTED NOT KNOWN
S ☐ NO SUCH NUMBER/ STREET
NOT DELIVERABLE AS ADDRESSED
- UNABLE TO FORWARD
☐ OTHER

RTS
RETURN TO SENDER

AUG 19 1996

OREGON STATE BOARD OF MEDICAL EXAMINERS
1500 S.W. 1ST AVE., #620
PORTLAND, OREGON 97201-5826
(503) 229-5770

Key 110 Code 831.914 (MD/DO) Key 123 Code 831.940 (DPM)

Applicant # 14583 | License # 20096 Date License Issued: 10/18/96

Application is: ☐ Approved ☐ Denied ☐ Withdrawn BOARD MEMBER'S INITIALS:

SPACE ABOVE THIS LINE FOR BOARD USE ONLY

# APPLICATION FOR LICENSURE for Oct. 18, 1996

| 1. FULL LEGAL NAME Last Name (Jr., II, etc.) | First Name | Middle Name | ☒ MD ☐ DO ☐ DPM |
|---|---|---|---|
| Burkett | Donna | Lynn | |

| 2. BUSINESS ADDRESS Street | City | State | Zip |
|---|---|---|---|
| OHSU - Family Practice 3181 SW Sam Jackson Park Rd | Portland | OR | 97201 |
| **3. RESIDENCE ADDRESS** Street | City | State | Zip |
| | | | |

| 4. BUSINESS TELEPHONE (Area Code) | 5. RESIDENCE TELEPHONE (Area Code) | 6. SOCIAL SECURITY NUMBER |
|---|---|---|
| (503) 494-9000 bpr # 0719 | | |

➡ Please indicate your mailing address: ☐ Business ☒ Residence

**7. PREMEDICAL EDUCATION** Name and location of college/university

Mars Hill College Mars Hill, NC

| BEGINNING DATE (Mo. Yr.) | ENDING DATE (Mo. Yr.) | DEGREE | DATE OF DEGREE |
|---|---|---|---|
| 8/86 | 5/90 | BA & BS | 5/90 |

**8. ADDITIONAL PREMEDICAL EDUCATION** Name and location of college/university

| BEGINNING DATE (Mo. Yr.) | ENDING DATE (Mo. Yr.) | DEGREE | DATE OF DEGREE |
|---|---|---|---|
| | | | |

| 9. MEDICAL EDUCATION Name, Location of Medical/Osteopathic/Podiatric School | DATES OF ATTENDANCE | BEGINNING DATE Mo. Day Yr. | ENDING DATE Mo. Day Yr. |
|---|---|---|---|
| University of North Carolina School of Medicine, Chapel Hill, NC | 1st Year | 8-21-91 | 5-92 |
| same as above | 2nd Year | 8-92 | 5-93 |
| same as above | 3rd Year | 6-28-93 | 6-26-94 |
| same as above | 4th Year | 6-27-94 | 3-21-95 5-14-95 |
| NA | 5th Year | | |
| | 6th Year | | |

| 10. MEDICAL/OSTEOPATHIC/PODIATRIC SCHOOL GRADUATED School, City, State/Country | DEGREE (mo., day, yr.) | ☒ MD ☐ DO ☐ DPM |
|---|---|---|
| University of North Carolina School of Medicine, Chapel Hill, NC | 5-14-95 | |



DO NOT DETACH ANY PART OF THIS FORM.

11. I have taken the following examinations:

☐ NBME (MD)
☐ NBOME (DO)
☐ NBPME (DPM)
☐ Part 1 Date Passed _____ ☐ Part 2 Date Passed _____ ☐ Part 3 Date Passed _____

☐ FLEX ☐ Day 1 Date Passed _____ ☐ Day 2 Date Passed _____ ☐ Day 3 Date Passed _____
State where taken _____ State where taken _____ State where taken _____

☐ FLEX ☐ Comp 1 Date Passed _____ ☐ Comp 2 Date Passed _____
State where taken _____ State where taken _____

☐ LMCC Date Passed _____

☐ NON-FLEX State where taken _____ Date Passed _____

☒ USMLE ☒ Step 1 Date Passed 6/93 ☒ Step 2 Date Passed 3/95 ☒ Step 3 Date Passed 5/96

12. ☐ SPEX State where taken _____ Date Passed _____

☐ ECFMG Date Passed _____ Date certificate issued _____

| 13. ALL LICENSES APPLIED FOR: State/Province/Country | RESULTS Explain Granted | Denied | Pending | LICENSE/CERTIFICATE Issued Mo. | Yr. | Number | PERM or TEMP | LICENSE OBTAINED BY USMLE | FLEX | Recip | Nat Bd | CURRENT Y | N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| OREGON | ✓ | | | 7 | 1/96 | LL06837 | temp (limited) | ✓ | | | | Y | |
| NO OTHERS | | | | | | | | | | | | | |
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DO NOT DETACH ANY PART OF THIS FORM.

# APPLICATION/REGISTRATION QUESTIONS

Answer all questions on both sides of this sheet. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification.

If you answer "yes" to any of the questions, you must provide a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

**NOTE:** Fraud or misrepresentation in applying for or procuring a license, registration or reactivation in Oregon are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations.

## Category I

1. Do you hold any licenses to practice another health care profession?
2. Have you ever failed a state or national examination to qualify for a state license to practice a health care profession?
3. Have you ever engaged in the unlicensed practice of any health care profession when you were required by law to have a license?
4. Has any state licensing board refused to issue, refused to renew, or denied you a license to practice?
5. Have you ever been asked to make a written or verbal response to an investigation or inquiry by a licensing board?
6. Has any licensing board ever taken any disciplinary action against you, or revoked, suspended, placed on probation, limited or restricted your license?
7. Have you ever been denied approval to prescribe controlled substances, or been charged with a violation of federal or state narcotic laws, or been asked to surrender your DEA number?
8. Have you ever been convicted of a felony or misdemeanor?
9. To your knowledge, are you currently the subject of any criminal or civil investigation?
10. Have any charges of malpractice been brought against you?
11. Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty?
12. Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation or been subject to formal disciplinary action during a medically related training program?
13. Have you ever had hospital privileges denied, reduced, restricted, suspended, or been placed on probation, revoked, requested to voluntarily resign, or been subject to staff disciplinary action?

The answers to these questions are exempt from public disclosure under ORS 192.505(2), the Oregon Public Records Law, unless a party seeking disclosure, by clear and convincing evidence, shows that disclosure would not be an unreasonable invasion of privacy and that the public interest requires disclosure in the particular instance. The answers to these questions may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

If applicable, these questions should be read to include the clause, "Other than what is known already to the Oregon Diversion Program for Health Professionals, . . ."

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed health care professional who prescribed the controlled substance or dangerous drug.

## Category II

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?

2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition?

3. Do you currently have, or have you had within the past 5 years, a dependency on the use of alcohol or drugs which impaired, or does impair, your ability to practice your health care profession safely and competently?

4. Within the past 5 years, have you engaged in the excessive or habitual use of alcohol or illegal drugs, or received any in-patient therapy/treatment or been hospitalized for alcoholism, or illegal drug use, or been arrested for a DUII (Driving Under the Influence of Intoxicants) or DWI (Driving While Intoxicated)?

5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .08% BAC (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional)?

☞ Signature_____ Date signed 7/27/96

16. **PERSONAL HISTORY** If any of the following questions are answered "yes," full details must be furnished on a form provided with this application (pages 5a & 5b). Include dates, names, addresses, circumstances, results, and copies of legal documents. If you need additional space, please make a copy of the form, sign and date it and submit it with your application. **See Page 2 of "Instructions for Completing the Licensure Application Form" for specific instructions in responding to the questions below.**

**PLEASE BE ADVISED THAT FRAUD OR MISREPRESENTATION IN APPLYING FOR OR PROCURING A LICENSE TO PRACTICE MEDICINE IN OREGON IS GROUNDS FOR DENIAL OF YOUR APPLICATION.**

**RESPONSES TO QUESTIONS 6, 7, 8, 11 AND 13 BELOW, WILL BE KEPT CONFIDENTIAL UNDER THE OREGON PUBLIC RECORDS LAWS.***

| | YES | NO | **DO NOT PROVIDE DETAILS TO THESE QUESTIONS ON THIS PAGE.** (See pages 5a & 5b for this purpose). |
|---|---|---|---|
| | ☐ | ☐ | 1. Have you ever failed to pass any State/Medical/Osteopathic/Podiatric examination; USMLE examination; FLEX examination; National Board of Medical/Osteopathic/Podiatric examination; PMLexis; or SPEX examination? |
| | ☐ | ☐ | 2. Have you ever engaged in the practice of medicine/podiatry in a state, district, or territory where you did not hold a valid license unless authorized to do so? |
| | ☐ | ☐ | 3. Have you ever had an application for licensure refused or denied by a licensing Board? |
| | ☐ | ☐ | 4. Have you ever been called before any State Board or Medical/Osteopathic/Podiatric Association/Society or Committee for interrogation concerning any violation of the Medical/Osteopathic/Podiatric Act; or for unethical conduct? |
| | ☐ | ☐ | 5. Has your license been revoked, suspended, or restricted or has there been any other disciplinary action against you in any state? |
| * | ☐ | ☐ | 6. Have you ever been hospitalized for mental illness, or do you have or have you been diagnosed with any physical injury, disease or mental condition which impairs your ability to practice medicine? |
| * | ☐ | ☐ | 7. Have you engaged in the excessive or habitual use of alcohol, or received any in-patient therapy/treatment or been hospitalized for alcoholism, or been arrested for a DUII (Driving Under the Influence of Intoxicants) or DWI (Driving While Intoxicated) within the last 10 years? |
| * | ☐ | ☐ | 8. Have you used any controlled substances for other than legitimate medical purposes or been treated, or hospitalized for an addiction to or dependency on controlled substances within the last 10 years? |
| | ☐ | ☐ | 9. Have you ever been denied a narcotic stamp, charged or convicted of a violation of Federal or State Narcotic Laws or been asked to surrender your Narcotic Stamp? |
| | ☐ | ☐ | 10. Have you ever been convicted of a felony or misdemeanor other than minor traffic violations? |
| * | ☐ | ☐ | 11. Have you ever had hospital staff privileges denied, reduced, removed, suspended or revoked or been subject to disciplinary action? |
| | ☐ | ☐ | 12. Have any charges of malpractice been brought against you? |
| * | ☐ | ☐ | 13. Do you now have a physical condition which might affect your ability to practice medicine? |
| | ☐ | ☐ | 14. Have you ever ceased the active practice of medicine/osteopathy/podiatry in your specialty? |
| | ☐ | ☐ | 15. Have you ever been restricted, suspended, terminated, requested to voluntarily resign, or been subject to formal disciplinary action during a postgraduate training program? |



DO NOT DETACH ANY PART OF THIS FORM.

15. **CHRONOLOGY OF ACTIVITIES** List ALL activities including training, employment, locum tenens, vacations in date order after medical/osteopathic/podiatric school up to and including the present date. Account for all periods of time & indicate specialty field for all training programs. (Use only standard abbreviations)

| TYPE OF ACTIVITY (trning, prac, vac) | TRAINING LEVELS - SPECIALTY FIELDS | NAME OF INSTITUTION, OR PLACE OF PRACTICE & MAILING ADDRESS | BEGINNING AND ENDING DATES Mo Dy Yr | Mo Dy Yr |
|---|---|---|---|---|
| EXAMPLE: Internship | PG1 (PD) | St. Joseph Hosp. 2223 S. W. 10th Ave. Portland, OR 97234 | 7 1 78 | 6 30 79 |
| Vacation (and moving) | | | | |
| | | | | |
| Internship | PG1 (Family Practice) | Oregon Health Sci. Univ. 3181 SW Sam Jackson Park Rd. Portland, OR 97201 | 7-1-95 | 6-30-96 |
| Residency | PG2 (Family Practice) | Same | 7-1-96 | present |
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**PLEASE LIST ALL ACTIVITIES (TRAINING, PRACTICE, VACATIONS, ETC.) UP TO THE PRESENT DATE.**



DO NOT DETACH ANY PART OF THIS FORM.

17. **DATE OF BIRTH** (Mo. Day Yr)

68

18. **PLACE OF BIRTH** City, state, or country

Hattiesburg MS

19. **PHYSICAL DESCRIPTION**

| HEIGHT | WEIGHT | EYES | HAIR |
|---|---|---|---|
| | | | |

ATTACH (STAPLE) PHOTOGRAPH

owing date taken on
raph

20. **MILITARY SERVICE (Branch)** _____ **FROM** (Mo. Day Yr.) _____
Active Duty Only **TO** (Mo. Day Yr.) _____
NONE **(Branch)** _____ **FROM** (Mo. Day Yr.) _____
**TO** (Mo. Day Yr.) _____

21. **MEDICAL SPECIALTY** Primary specialty you plan to practice in Oregon

Family Practice

22. **DATES OF OREGON PRACTICE** (If you will be training in Oregon, show N/A. See 23 below.)

Beginning Date: N/A ☐ Show physician/hospital/clinic & city:

23. **DATES OF OREGON TRAINING**

From: 7/1/95 To: 6/30/98

☒ Residency (list hospital): Oregon Health Sciences University
☒ Residency Specialty: Family Practice
☐ Fellowship (list hospital): _____
☐ Fellowship Specialty: _____

| 24. AMERICAN SPECIALTY BOARD | CERTIFICATE NO. | CERTIFIED (Mo. Day Yr.) |
|---|---|---|
| N/A | | |
| **AMERICAN SPECIALTY BOARD** | **CERTIFICATE NO.** | **CERTIFIED** (Mo. Day Yr.) |
| | | |
| **25. AMERICAN SPECIALTY BOARD** | **CERTIFICATE NO.** | **RECERTIFIED** (Mo. Day Yr.) |
| N/A | | |
| **AMERICAN SPECIALTY BOARD** | **CERTIFICATE NO.** | **RECERTIFIED** (Mo. Day Yr.) |
| | | |

**RELEASE/AFFIDAVIT OF APPLICANT**

I, Donna Lynn Burkett, being first duly sworn, depose and say that I am the
(Applicant TYPE or PRINT full legal name)
person above described and identified; that I have not engaged in any of the acts prohibited by the statutes of the state of Oregon, particularly those acts set forth in Sections ORS 677.080 or 677.190.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates, business associations (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 requested by this board in connection with the processing of this application. I further authorize this board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine/podiatry during the time that I am a licensee of this board.

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

(Applicant to sign usual business signature
in presence of Notary Public)

Affix a Legible Seal Here

Subscribed and sworn to me before this 7th day of August 19 96

Notary signature Donna E. Charron

Notary Public for State of Oregon

My commission expires 10/27/96



DO NOT DETACH ANY PART OF THIS FORM.

# The University of North Carolina
## at Chapel Hill

To all to whom these presents shall come

**Greeting**

Be it known that

**Donna Lynn Burkett**

having completed the studies and fulfilled the requirements of the Faculty for the degree of

**Doctor of Medicine**

has accordingly been admitted to that degree, with all the rights, honors, and privileges thereunto appertaining.
In witness whereof, the Seal of the University and the signatures of duly authorized officers are affixed to this diploma.

Given at Chapel Hill, in the State of North Carolina, this fourteenth day of May
in the year nineteen hundred and ninety-five
and of this University the two hundred and sixth.

Chairman of the Board of Governors
The University of North Carolina

President
The University of North Carolina

Chairman of the Board of Trustees
The University of North Carolina at Chapel Hill

Chancellor
The University of North Carolina at Chapel Hill

Dean

SEAL
1996

Donna E. Burkett 2/8/96