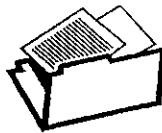


FILE CONTENT:	application file	
FILE NUMBER:	MD00045964	
FILE NAME:	Rebecca Jones	
Pages	Information Withheld	Exemption
1	none	RCW 42.56.350(2) and 42.56.050.
2	Licensee address and ssn	RCW 42.56.350(1) and (2), 42 USC Section 405(c)(2)(vii)(1).
3 to 6	none	
7	Licensee address and ssn	RCW 42.56.350(1) and (2), 42 USC Section 405(c)(2)(vii)(1).
8	Health Care Information regarding the respondent	RCW 42.56.360(2) and RCW 70.02.020
9 to 11	Whistleblower/Complainant name, address, phone, friend, family member	RCW 43.70.075, (identity of whistleblower protected) and RCW 70.02.020.
12 to 14	Patient identifier	RCW 43.70.075 and RCW 70.02.020.
15	Whistleblower/Complainant name, address, phone, friend, family member	RCW 43.70.075, (identity of whistleblower protected) and RCW 70.02.020.
16 to 18	Transcripts	Family Educational Rights and Privacy Act, 20 USC Section 1232(g)
19 to 23	none	
24	Licensee ssn	RCW 42.56.350(1), 42 USC Section 405(c)(2)(C)(vii)(1) and (viii)(I)
25	Licensee address	RCW 42.56.350(2) and 42.56.050.
26 to 32	none	



CREDENTIALING UNIT TRANSMITTAL SHEET

FULL APPLICATION TEMPORARY PERMIT LIMITED APPLICATION

FILE COMPLETED _____ <small>(DATE)</small>	SUBMITTED FOR REVIEW <u>12/27/05</u> <small>(DATE)</small>	
FILE APPROVED <input checked="" type="checkbox"/> <small>(SEE WORKSHEET FOR SIGNATURE)</small>	FILE INCOMPLETE <input type="checkbox"/>	FILE RETURNED _____
ITEMS IDENTIFIED AS INCOMPLETE/INCORRECT:		
●		ITEM RECEIVED _____
●		_____
●		_____
●		_____
FILE RE-SUBMITTED FOR REVIEW _____ <small>(LAST DOCUMENT DATE)</small>		
EXCEL REPORT UPDATED <input type="checkbox"/>		
FILE APPROVED <input type="checkbox"/> <small>(SEE WORKSHEET FOR SIGNATURE)</small>	FILE INCOMPLETE <input type="checkbox"/>	FILE RETURNED _____
ITEMS IDENTIFIED AS INCOMPLETE/INCORRECT:		
●		ITEM RECEIVED _____
●		_____
FILE RE-SUBMITTED FOR REVIEW _____ <small>(LAST DOCUMENT DATE)</small>		
EXCEL REPORT UPDATED <input type="checkbox"/>		
FILE APPROVED <input type="checkbox"/> <small>(SEE WORKSHEET FOR SIGNATURE)</small>	FILE INCOMPLETE <input type="checkbox"/>	FILE RETURNED _____
ADDITIONAL COMMENTS:		

AAAAAA SSSSSS IIIIIIIIIII
AAAAAAA SSS SSS IIIIIIIIIII
AAAAAAA SSS SSS III

MEDICAL BOARD
bjel303

ASSESSMENT SYSTEMS, INC.
REAL SYSTEM

12-22-05
02:14:54 PM
V2.5.74
REFERENCE # MC00018183
SOC SEC NUM

INDIVIDUAL NAME
LAST JONES
FIRST REBECCA
MIDDLE K

+--ADDITIONAL INFORMATION-----+
SEX F = MARRIED Y =

OTHER NAME
CORP. OFFICER =
TRUST ACCOUNT

BIRTH PLACE PITTSBURGH PA
DATE 11-17-1955

SCHOOL CODE 039050
CE UNITS 0.00 REQD BY - -

RESIDENCE INFORMATION

PHONE: () - COUNTY: 51
() - LGL ST:

NOTES

+-----+
| CURRENT STATUS: U EXPIRATION DATE: 12-22-2005 FIRST ISSUE DATE: 12-22-2005 |
| RENEWAL STATUS: LAST ACTIVE DATE: - - LAST RENEWAL DATE: - - |
| COMPLAINTS O/C: 0/ 0 AUTHORITY: |
+-----+

1MENU #1 2AUTH DAT 3APPT DAT 4LICS DAT 5 ACCOUNT 6 7 8

Medical Quality Assurance Commission Physician Application Worksheet

Name JONES REBECCA Date of Birth 11/17/1955

Date Received 12/19/2005 Cash Number _____ Candidate Number _____

WSP Check Fees Photo Data1-13 AIDS Attest SSN Garfield Search

Chronology Complete _____ to _____
 Temp Permit Issued Number: _____
 12/22/05 FSMB 12/22/05 AMA ECFMG Archive File

Personal Data "Yes"s	Documentation Requirements	Malpractice Cases	Synopsis	Disposition
#9 _____	_____	1 _____	X	X
_____	_____	2 _____		
_____	_____	3 _____		
_____	_____	4 _____		

Medical School U OF PENN School Code 1991 U.S. Canadian International
 Name U OF PENN Year of Degree 1991 12/9/05 Transcripts Translations

Examination Type National Boards FLEX USMLE State Exam LMCC 12/9/05 Scores Received

Received	Post Graduate Training Programs	Accreditation Verified	Received	Post Graduate Training Programs	Accreditation Verified
12/12/05	READING 6/91-6/95				

Received	PA	Accreditation Verified	Comments
12/8/05	PA	<input checked="" type="checkbox"/>	READING

Approved Walter A. Berg Signature 1/5/06 Date

Comments: Re: Malpractice Case approved by A. Berg

Deficiency Letters:

<input type="checkbox"/> January	<input type="checkbox"/> April	<input type="checkbox"/> July	<input type="checkbox"/> October	<input type="checkbox"/>
<input type="checkbox"/> February	<input type="checkbox"/> May	<input type="checkbox"/> August	<input type="checkbox"/> November	<input type="checkbox"/>
<input checked="" type="checkbox"/> March	<input type="checkbox"/> June	<input type="checkbox"/> September	<input type="checkbox"/> December	<input type="checkbox"/>

MEDICAL QUALITY ASSURANCE COMMISSION

STAFF MEDICAL CONSULTANT REVIEW

APPLICANT NAME: Jones, Rebecca DATE REVIEWED 1/5/06

SUBMITTED BY: Hoep

MEDICAL CONSULTANT,
PLEASE REVIEW THE MALPRACTICE INFORMATION IN THE ATTACHED
APPLICATION FILE.

APPROVED: ✓ DISAPPROVED: _____ DATE: 1-05-06

SIGNATURE: [Signature]

COMMENTS: _____

PHYSICIAN & SURGEON



325

REVENUE SECTION



PRINT NAME

Jones, Rebecca

RETURN THIS PORTION
WITH CHECK & APPLICATION

⑈0566⑈

1F 0252090000 00236

053490566

0566-12/15/2005 11:17:06 AM-0600 4325.00

Background Check Processed

DEC 1 2005

RECEIVED DEPARTMENT OF HEALTH INVESTIGATION SERVICE UNIT

DEC 09 2005

FOR OFFICE USE ONLY

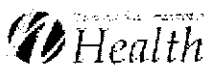
ISSUANCE DATE

DEPARTMENT OF HEALTH HEALTH PROFESSIONALS

LICENSE #

45964

LICENSE #



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

Application For License To Practice Medicine Applicable For MD's Only

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

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

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

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL
	JONES	REBECCA	K

ADDRESS

CITY	STATE	ZIP	COUNTY
			BERKS

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

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 26.23 RCW)

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)
<input checked="" type="checkbox"/> Female <input type="checkbox"/> Male	11/17/1955	Pittsburgh, PA

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

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

If yes, list name(s):

HEIGHT	WEIGHT
5' 3"	110 lbs

EYE COLOR	HAI R COLOR
blue	brn / grey

MEDICAL SCHOOL	YEAR OF GRADUATION
University of Pennsylvania	1991

MEDICAL SPECIALTY
OB/GYN



Rebecca Jones
12/6/05

2. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?

4. Are you currently engaged in the illegal use of controlled substances?

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

a. the use or distribution of controlled substances or legend drugs?

b. a charge of a sex offense?

c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?

b. committed any act involving moral turpitude, dishonesty or corruption?

c. violated any state or federal law or rule regulating the practice of a health care professional?

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?

2. Personal Data Questions (Continued)

YES NO

- 10. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? YES NO
- 11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? YES NO
- 12. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application? YES NO
- 13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? YES NO

3. Education And Experience

Provide a chronological listing of your educational preparation and post-graduate training.
(Attach additional 8 1/2 X 11 sheets if necessary.)

Schools Attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Number of Years Attended	Dates Attended		Diploma or Degree Obtained (Quote titles in original language and translate to English.)
		From (mo/yr)	To (mo/yr)	
Medical Education (List all Medical Schools Attended)				
University of Pennsylvania	5	9/86	5/91	MD
1988-89 was spent raising my infant son and teaching				
Post-Graduate Training (List all Programs Attended)				
Reading Hospital and Medical Center, Reading, PA	4	6/91	6/95	Internship + residency in OB/GYN

4. Professional Experience

In chronological order list all professional experience received since graduation from medical school to the present.
(Exclude activities listed under other sections, identify any periods of time break of 30 days or more.)
(Attach additional 8 1/2 X 11 sheets if necessary.)

	Dates of Experience	
	From (mo/yr)	To (mo/yr)
Independent contractor Planned Parenthood, Reading, PA	11/05	present
Locum tenens Brandywine Hospital Brandywine PA	10/05	11/05
Private practice Reading OB/GYN, PC. 3611 Perkasie Ave, Reading, PA	7/95	10/05

5. Hospital Privileges

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years.
(Attach additional 8 1/2 X 11 sheets if necessary.)

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	Dates	
	Beginning (mo/yr)	Ending (mo/yr)
Reading Hospital and Medical Center	7/95	10/05

6. Licenses In Other States

List all licenses to practice medicine in any state, Canadian province or other country.
(Include whether active or inactive.)

State, County or Province	Date License Issued	License Number	Basis of Licensure		Status of License		Any Limitations on License
			Examination (Date Passed)	Endorsement	Active	Inactive	
Pennsylvania	8/31/93	MD 751312L		✓	✓		<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
							<input type="checkbox"/> No <input type="checkbox"/> Yes
							<input type="checkbox"/> No <input type="checkbox"/> Yes
							<input type="checkbox"/> No <input type="checkbox"/> Yes

7. Fifth Pathway (foreign-trained applicants only) (Attach additional 8 1/2 X 11 sheets if necessary.)

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

8. AIDS Affidavit

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my registration may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS RJ	DATE 12/6/05
----------------------------	-----------------

9. Applicant's Attestation

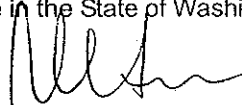
I, Rebecca K. Jones, Name of Applicant, certify that I am the person described and identified in

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, 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 the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.



Signature of Applicant

12/6/05

Date

Official Use Only

Washington State Records Center

REC'D
DEC 15 2005
050

Washington State Medical Quality Assurance Commission Applicant's Professional Liability Action History

Applicant's Name:

Today's Date:

Please submit a *separate form for each past or current professional liability claim or lawsuit* which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

- 1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

Date of occurrence: 5/29/2001 Details: See Summary

Patient underwent laparoscopy for ovarian tumor and sustained injury to a major blood vessel. She required a transfusion but had full recovery. She alleged negligence in trocar placement. A jury found me non-negligent on 4/28/2005.

- 2) Date suit or claim was filed: 11/7/2001 Name and address of Insurance Carrier that handled the claim: Pro National - Mary Lindholm Claims Consultant
2600 Professionals Drive, Box 150, Okemos, MI 48865

- 3) Your status in the legal action (primary defendant, co-defendant, other): primary defendant
- 4) Current status of suit or other action: Jury trial in 4/05
- 5) Date of settlement, judgment, or dismissal: Defense verdict 4/28/05
- 6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. (You must enclose a copy of final disposition of case—this includes dismissals.) \$

I verify the information contained in this form is correct and complete to the best of my knowledge:

12/6/05

Signature

Date

Summary of [redacted] v. Rebecca K. Jones

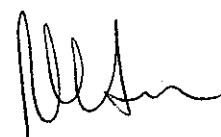
[redacted] was a 24 yr. old nulligravida who underwent MRI on 4/26/2001 to evaluate chronic pain that had arisen following a motor vehicle accident in 2000. MRI findings were negative with the exception of a pelvic mass consistent with an ovarian dermoid tumor. On 5/11/2001, an ultrasound confirmed these findings, revealing the presence of a 7 cm left ovarian dermoid cyst. [redacted] had been under my care for 5 years (and had previously had a functional cyst of the opposite ovary which resolved spontaneously). I advised surgical removal of the dermoid cyst.

[redacted] and I discussed the plans by phone when I received the ultrasound report and again at an in-office preoperative meeting on 5/21/2001. We discussed surgical options of laparoscopy v. laparotomy, and oophorectomy v. cystectomy. [redacted] was adamant in her desire to preserve her left ovary. We discussed risks including bleeding, organ injury, and the high probability of the need for laparotomy (based on the size of the tumor and her request for ovarian conservation). One major concern was the patient's long-planned June wedding. She did not want to delay surgery until after the wedding; nor did she want surgery to interfere with her plans. We agreed on attempted laparoscopic removal with the understanding that there was a high likelihood of conversion to laparotomy. The plans were discussed a third time on the day prior to surgery by phone. The patient is well-educated (master's degree) and was thoroughly counseled.

On 5/29/2001, the patient presented for laparoscopic cystectomy, possible laparotomy. She is approximately 4 ft 11 inches, and weighed 95 lbs. A pneumoperitoneum was established without difficulty. Trocar insertion was complicated by vascular injury that was immediately identified and the procedure was converted to laparotomy (with a "bikini" incision). A vascular surgeon promptly carried out repair of the right and left iliac veins at the bifurcation. Ovarian cystectomy was performed without difficulty. The patient received 2 units of PRBC intraoperatively and went on to have an uncomplicated postoperative course. There is no reason to expect any future medical complications from the surgery and in fact the patient has gone on to carry two spontaneous, normal pregnancies to term.

The patient alleged many errors and damages, principle among them: surgical error with improper trocar placement, insufficient pneumoperitoneum, disfigurement, emotional injuries, and fatigue, especially at her wedding and on her honeymoon. My defense was trocar malfunction and the need for laparotomy regardless of the vascular injury due to the solid nature of the >7cm tumor. The patient sustained a recognized complication of the procedure and it was promptly and skillfully managed. (Incidentally, the trocar manufacturer was also named and settled for an undisclosed sum.)

After a four day jury trial in Phila, PA in 4/2005, I was found not negligent. I was represented by George Young, 215 569-1001 and insured by ProNational (Mary Lindholm, 517 347-6268).


12/16/2005

May 24, 2005

PERSONAL AND CONFIDENTIAL

Rebecca Jones, M.D.
C/O Reading OB/GYN, P.C.
3611 Perkiomen Avenue
Reading, PA 19606

RE: RE: Jones
Claim No.:

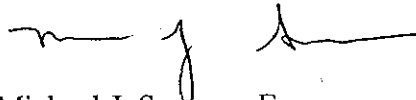
Dear Dr. Jones:

One of the business duties we enjoy most is the privilege of offering congratulations to insured doctors who have experienced a successful defense of an alleged malpractice claim. In achieving vindication, you demonstrated the conviction and courage to face the turmoil of the legal process and stand up for your rights. Please accept this note as a personal and cordial thank you for your efforts and cooperation in resolving this difficult matter.

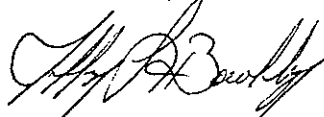
As you know, ProNational believes in the wisdom and value of a vigorous defense when there is no negligence. In addition to vindicating your actions, a strong and vigorous defense helps the profession by discouraging the filing of frivolous or nonmeritorious malpractice claims. We could not pursue this goal without the involvement and support of physicians like yourself. For your efforts, ProNational again extends its thanks.

If you have comments concerning the manner in which your case was handled, or if you have suggestions on how we can support or improve our continuing efforts to fight malpractice claims, please contact either one of us at our regional office in Michigan (800) 292-1036.

Sincerely,



Michael J. Severyn, Esq.
Vice President, Claims



Jeff Bowlby
Senior Vice President

/dlr

cc George Young, Esq.
CLA Insurance

VS.
REBECCA K. JONES, M.D.,

VERDICT SHEET

Question 1:

Has the plaintiff, _____ proven by a preponderance of the evidence that the defendant, Rebecca Jones, M.D., was professionally negligent?

_____ Yes

_____ No

If your answer to Question #1 is "Yes," proceed to Question #2.

If your answer to Question #1 is "No," the plaintiff cannot recover. You should not answer any further questions and should return to the courtroom.

Question 2:

Has the plaintiff, _____ proven by a preponderance that the negligent conduct of Rebecca Jones, M.D., was a factual cause in bringing about injuries to the plaintiff?

_____ Yes

_____ No

If your answer to Question #2 is "Yes," please proceed to Question #3.

If your answer to Question #2 "No," the plaintiff cannot recover. You should not answer any further questions and should return to the courtroom.

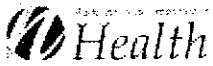
Question 3:

State the total amount of damages, if any, sustained by the plaintiff.

\$ _____

DATE: 4/28/2005

JURY FOREPERSON



MD

RECEIVED

DEC 12 2005

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

TO: Post Graduate Training Program Director

Reading Hospital

P.O. Box 16052

Philadelphia PA 19101

RE: Verification/Evaluation of Training

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, directly to the address shown below. All questions must be answered.

Rebecca Jones
APPLICANT (PRINT OR TYPE)

11/17/55
BIRTHDATE

See Release
SIGNATURE OF APPLICANT

1. _____ is or was engaged in postgraduate training in our program
from 7/1/1991 to 6/23/1995
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

in the field of OB/GYN

- 2. At the time this individual was in training, was this program accredited through the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons, or the College of Family Physicians of Canada? Yes No
- 3. Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? Yes No
If yes, please explain _____

Return to:
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Signature [Signature]
Title CUMIP Program Director
Hospital THE READING HOSPITAL MEDICAL CENTER
Address PO Box 16052
READING PA
Date 12/7/05
Telephone 610-989-8827

(SEAL)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

RECEIVED
DEC 08 2005
DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

December 2, 2005

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

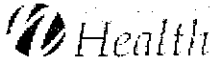
NAME:	REBECCA KEENE JONES
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD051312L
ORIGINAL LICENSURE DATE:	08/31/1993
EXPIRATION DATE:	12/31/2006
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

SEAL



Commissioner
Bureau of Professional and Occupational Affairs



MD

TO: Hospital Administration

Reading Hospital

HOSPITAL NAME

PO BOX 116052

ADDRESS

Reading PA 19612

RECEIVED

DEC 28 2005

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

RE: Verification and Evaluation of Privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information directly to the address shown below at your earliest convenience. All questions must be answered.

Rebecca Jones

APPLICANT (PRINT OR TYPE)

11/17/85

BIRTHDATE

See Release

SIGNATURE OF APPLICANT

1. _____ now has/had admitting or speciality privileges at this hospital

from 05/25/95 to Present
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

Yes No

If yes, please explain

3. Has the applicant ever been asked to resign?

Yes No

If yes, please explain

Return to:

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

(SEAL)

Gerald P. Malick

Gerald P. Malick, M.D.
Vice-President/Medical Affairs

Signature _____

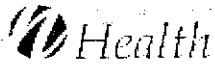
Title _____

Hospital See Above
PLEASE TYPE OR PRINT

Address _____

Date _____

Telephone _____



MD

TO: Hospital Administration

Brandywine Hospital
HOSPITAL NAME
201 Reeceville Rd
ADDRESS
Coatesville PA 19320

RECEIVED

DEC 27 2005

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

RE: Verification and Evaluation of Privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information directly to the address shown below at your earliest convenience. All questions must be answered.

Rebecca Jones
APPLICANT (PRINT OR TYPE)

11/17/85
BIRTHDATE

See Release
SIGNATURE OF APPLICANT

1. Rebecca Jones now has/had admitting or speciality privileges at this hospital

from 10/04/2005 to 11/2/2005
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

Yes No

If yes, please explain

3. Has the applicant ever been asked to resign? Yes No

If yes, please explain

Return to:

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

(SEAL)

Signature Lorena Keresko
Title Medical Staff Coordinator
Hospital _____
Address Medical Staff Office
Brandywine Hospital
201 Reeceville Road
Coatesville, PA 19320
Date 12/21/05
Telephone 610-383-8006

The Federation of State Medical Boards
of the United States, Inc.

PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
FAX (817) 868-4099

BOARD ACTION SEARCH RECONCILIATION REPORT

December 5, 2005

Washington Quality Med Assur
Attn: Blake Maresh, Exec Dir.
310 Israel Road SE
PO Box 47860
Tumwater, WA 98501

RECEIVED
DEC 07 2005
DEPARTMENT OF HEALTH

Re: Board Action Query Dated: December 5, 2005
Your Reference Number:
FSMB Batch Number: BQ1204872

PRACTITIONERS CLEARED WITH NO ACTION AS OF APPLICABLE SEARCH DATE

Name	DOB	School	Yr/Grad	Request ID
Jones, Rebecca	11/17/1955	039050	1991	16368686

Please refer to prior clearance reports to determine the search date for each practitioner.

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

November 23, 2005

DEC 05 2005

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
P.O. Box 619850
Dallas, TX 75261-9850


DALE L. AUSTIN
SENIOR VICE PRESIDENT
AND CHIEF OPERATING OFFICER

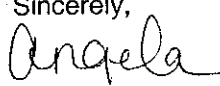
The **Washington** State Medical Board requests a disciplinary report on the following individual:

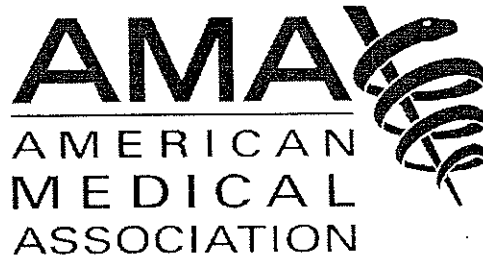
Name: Rebecca Jones, MD
Date of Birth: 11/17/55
Social Security #: -----
Medical School & Branch Location: University Of Pennsylvania-Philadelphia, Pa
Date of Graduation: 05/01/91

Please forward your response to the following address:

Washington Medical Quality Assurance Commission
Medical Section
310 Israel Road SE
Tumwater, WA 98501-7866

Please use the enclosed prepaid Federal Express airbill to expedite your response. On behalf of Dr. Jones, thank you for your assistance. If you have any questions about this request, please feel free to call me at 800-328-3065.

Sincerely,

Angela M. Wonnacott
Licensing Coordinator



RECEIVED

NOV 28 2005

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

AMA Physician Profile

Name and Mailing Address:

REBECCA KEENE JONES MD

Primary Office Address:

READING OB-GYN
3611 PERKIOMEN AVE
READING PA 19606-2712

Phone: UNKNOWN

Birthdate: 11/17/1955

Birthplace: PITTSBURGH, PA UNITED STATES OF AMERICA

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

———— All Information from this Point Forward is Provided by the Primary Source —————

Current and/or Historical Medical School:

UNIV OF PA SCH OF MED, PHILADELPHIA PA 19104

Degree Awarded: Yes

Degree Year: 1991

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 or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; provided however, that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** 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.

AMA makes no representations or warranties, either expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.



AMA Physician Profile

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

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: READING HOSP MED CTR
Specialty : OBSTETRICS & GYNECOLOGY

State: PENNSYLVANIA
 07/1990 - 06/1995
 (VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1992

Current and/or Historical Medical Licensure:

<u>Jurisdiction</u>	<u>MD/DO</u>	<u>Date Granted</u>	<u>Expiration Date</u>	<u>Status</u>	<u>License Type</u>	<u>Last Reported</u>
PENNSYLVANIA	MD	06/24/1994	06/23/1995	INACTIVE	RESIDENT	09/16/2005
PENNSYLVANIA	MD	08/31/1993	12/31/2006	ACTIVE	UNLIMITED	09/16/2005

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certification:

Applicant Number:

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

Federal Drug Enforcement Administration:

* Only the last three characters of active DEA number(s) are displayed.

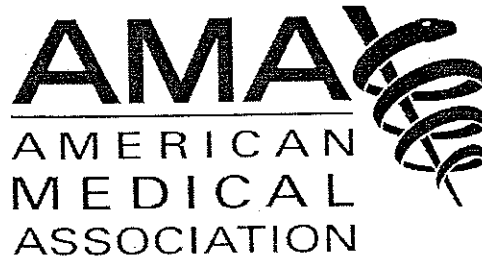
<u>DEA Number *</u>	<u>Schedule</u>	<u>Expiration Date</u>	<u>Last Reported</u>
XXXXXX799	22N 33N 4 5	12/31/2005	11/03/2005

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

AMA Physician Profile (continued)

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AMA Physician Profile

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY

Certificate: OBSTETRICS & GYNECOLOGY

Certificate Type: GENERAL

<u>Duration</u>	<u>Effective</u>	<u>Expiration</u>	<u>Occurrence</u>	<u>Last Reported</u>
TIME LIMITED	12/31/2004	12/31/2007	RE-CERT	11/09/2005
TIME LIMITED	12/31/2003	12/31/2007	RE-CERT	11/09/2005
TIME LIMITED	12/31/2002	12/31/2007	RE-CERT	11/09/2005
TIME LIMITED	12/31/2001	12/31/2007	RE-CERT	11/09/2005
TIME LIMITED	12/31/2000	12/31/2007	RE-CERT	11/09/2005
TIME LIMITED	11/07/1997	12/31/2007	INITIAL	11/09/2005

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

*This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties. Copyright 2005 American Board of Medical Specialties. All right reserved.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINISTRATION OR THE US PUBLIC HEALTH SERVICE.

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 or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; provided however, that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** 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.

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AMA Physician Profile

Additional Information:

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

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site (<http://www.ama-assn.org/go/amaprofiles>) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800-665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

AMA Physician Profile (continued)

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