telnet (GothomCity2)

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                      AAAAAA     SSSSSS    IIIIIIIIII
                     AAAAAAA    SSS  SSS   IIIIIIIIII
                    AAAAAAAA    SSS    SSS      III
MEDICAL BOARD            ASSESSMENT SYSTEMS, INC.                  04-13-07
bje1303                         REAL SYSTEM        V2.5.74         12:45:19 PM
INDIVIDUAL NAME                  (JR,SR,III)       REFERENCE # ML20008243
   LAST KOVICH                                     SOC SEC NUM
  FIRST HEATHER                        +-ADDITIONAL INFORMATION----------------+
 MIDDLE C                              |          SEX F =      MARRIED N =      |
                                       |                                        |
RESIDENCE INFORMATION                  |   OTHER NAME                           |
                                       |CORP. OFFICER                       =   |
                                       |TRUST ACCOUNT                           |
                                       |                                        |
                                       |  BIRTH PLACE PHILADELPHIA PA           |
                                       |        DATE 03-07-1977                 |
PHONE: (   )    -      COUNTY:   17    |                                        |
       (   )    -      LGL ST:         |SCHOOL CODE 039080                      |
                                       |   CE UNITS    0.00 REQD BY   -  -      |
NOTES                                  +----------------------------------------+

+-------------------------------------------------------------------------------+
|CURRENT STATUS: A    EXPIRATION DATE: 07-31-2007  FIRST ISSUE DATE: 06-24-2005|
|RENEWAL STATUS: Z   LAST ACTIVE DATE:   -  -     LAST RENEWAL DATE: 08-07-2006|
|COMPLAINTS O/C:  0/ 0      AUTHORITY: RE                                       |
+-------------------------------------------------------------------------------+
1GO BACK  2NAM&ADDR 3EDUCATE  4LIC FUNC 5INVESTG  6         7OTHR DAT 8EXTD NOT
```

Medical Quality Assurance Commission
Physician Application Worksheet

Name KOVICH HEATHER Date of Birth 03/07/1977

Date Received 4/12/07 Cash Number _____ Candidate Number _____

x	WSP Check	x	Fee	x	Photo	x	Data1-13	x	AIDS	x	Attest	x	SSN	x	Garfield Search

Chronology ☐ Complete

☐ Temp Permit Issued Number: _____

FSMB	AMA	ECFMG	Archive File
4/16/07	4/16/07		

Personal Data "Yes"s	Documentation Received	Malpractice Cases	Synopsis	Disposition
		1		
		2		
		3		
		4		

Medical School School Code _____ ☐ U.S. ☐ Canadian ☐ International

Name TEMPLE Year of Degree 2005 XXX Transcripts ☐ Translations

Examination Type ☐ National Boards ☐ FLEX ☐ USMLE ☐ State Exam ☐ LMCC 4/5/07 Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Graduate Training Programs	Accrediation Verified
6/15	U OF WASH 6/05-07				

7/24	MT		

Approved Helen S Boop Signature 7/26/07 Date

Comments:

Deficiency Letters:

☐	January	☐	April	☐	July	☐	October	☐	
☐	February	☐	May	☐	August	☐	November	☐	
☐	March	☐	June	☐	September	☐	**December**	☐	

PHYSICIAN & SURGEON (~~OTHER~~)

LOG

Washington State Department of Health

135

REVENUE SECTION

PRINT NAME Kovich, Heather

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236

II" 1 1 5 7 II"

07100157

1157-4/10/2007 3:44:29 PM-602 USSD9

Background Check Processed

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

APR 12 2007
DOH
Department of Health
Investigation Service Unit

ISSUANCE DATE

LICENSE #

FOR OFFICE USE ONLY
48623

LICENSE #

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

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

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

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

1. Demographic Information

APPLICANT'S NAME LAST: KOVICH FIRST: HEATHER MIDDLE INITIAL: C

ADDRESS

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

COUNTY: King

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, 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): 1 - DOH Licensee Health Professional Home Address and/or Ph...

SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 26.23 RCW): 2 - DOH Licensee Social Security Number - RCW 42.56....

GENDER: ☒ Female ☐ Male

BIRTHDATE (MO/DAY/YEAR): 3/7/1977

PLACE OF BIRTH (CITY/STATE): Philadelphia, 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: 5 ft 3 inches

WEIGHT: 135 lb

EYE COLOR: grey

HAIR COLOR: brown

MEDICAL SCHOOL: Temple U. Sch. of Medicin

YEAR OF GRADUATION: 2005

MEDICAL SPECIALITY: Family Medicine

DOH 657-020 (REV 6/2006)

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 ongoing treatment, 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. The Department does criminal background checks on all applicants.

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

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

   b. a charge of a sex offense? ☐ ☒

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

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

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

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

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

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

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

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

2. Personal Data Questions (Continued)

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

3. Education And Experience

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

Schools Attended (Location if other than U.S , quote names of schools in original language and translate to English.)	Number of Years Attended	Dates Attended From (MO/YR)	Dates Attended To (MO/YR)	Diploma or Degree Obtained (Quote titles in original language and translate to English.)
Medical Education (List all Medical Schools Attended)				
Temple University S.O.M.	4	9/01	6/05	MD
Post-Graduate Training (List all Programs Attended)				

4. Professional Experience

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

	Dates of Experience From (MO/YR)	Dates of Experience To (MO/YR)
University of Washington family medicine Residency	6/05	present

5. Hospital Privileges

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

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	Dates Beginning (MO/YR)	Dates Ending (MO/YR)
~~University of Washington affiliated hospitals~~ (resident physician only) enw	6/05	present

6. Licenses In Other States

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

State, County or Province	Date License Issued	License Number	Basis of Licensure: Examination (Date Passed)	Basis of Licensure: Endorsement	Status of License: Active	Status of License: Inactive	Any Limitations on License
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ 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)	Dates Attended: Ending (MO/YR)

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

APPLICANT'S INITIALS	DATE
HMC	3/7/07

9. Applicant's Attestation

I, Heather Kovich, certify that I am the person described and identified in
Name of Applicant

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.

Heather Kovich
Signature of Applicant

3/7/07
Date

Official Use Only

Washington State Records Center

HPQA RECEIVED

APR 11 2007

CSC

US·MLE
United States
Medical
Licensing
Examination™

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 04/05/2007

Recipient:

Washington Medical Quality Assurance Commission
ATTN: Doron Maniece, Exec Director
310 Isreal Road SE
Tumwater, WA 98501

Examinee: Kovich, Heather
Alt Name(s): Kovich, Heather Clare

Examinee ID#: 5-118-763-1
Date of Birth: 03/07/1977

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

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/21/2003	Pass	239	182	97	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	08/07/2004	Pass	248	182	99	75	

Clinical Skills (CS)*

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	10/02/2004	Pass					

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
WASHINGTON	09/07/2006	Pass	241	184	99	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Interpretation of results
USMLE transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., "Incomplete." On those Step examinations for which numeric scores are reported, two different scales are used. The first is a three-digit score scale on which most scores fall between 140 and 280. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration. The second is a two-digit scale on which a score of 75 is the recommended minimum passing score. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points on the three-digit scale and 1 to 2 points on the two-digit scale.

STEP 2 CLINICAL SKILLS (CS)
The Clinical Skills (CS) component of Step 2 was introduced in 2004 and the USMLE transcript has been modified to reflect this change. The Step 2 examination that existed prior to the introduction of Step 2 CS continues to be administered as the Clinical Knowledge (CK) component of Step 2. The label "Step 2 CK" is used for this examination whether taken before or after the introduction of the Step 2 CS component.

Step 2 CS results are reported as pass or fail. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

Some individuals may be required to take and pass Step 2 CS prior to registering for Step 3. Transcript users can find information on eligibility requirements for all USMLE examinations in the *USMLE Bulletin of Information* and from periodic Step 2 CS updates, available at the USMLE website (www.usmle.org).

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

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed within this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

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

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

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

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

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"
The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record to the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

TEMPLE UNIVERSITY

OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION
SCHOOL OF MEDICINE
3400 NORTH BROAD STREET
PHILADELPHIA, PENNSYLVANIA 19140

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DATE 04/13/07
TIME 02:10 PM

KOVICH, HEATHER C

SOCIAL SECURITY NUMBER
2 - DOH Licensee So...
00849358

COLL MEDICAL
CURR MEDICINE

DEPARTMENT	COURSE	COURSE TITLE	GRD
PROFESSIONAL MEDICAL EXTRACT			
MD		AWARDED 05/2005	
COLLEGE: MEDICAL		MAJOR: MEDICINE	
FALL 2001		MEDICAL	
ANAT/CE	M101	GROSS ANATOMY	P
ANAT/CE	M102	HISTOLOGY	HP
ANAT/CE	M104	EMBRYOLOGY	P
PSYCHIA	M113	BEHAVIORAL SCIENCE	HP
SPRING 2002		MEDICAL	
BIOCHEM	M119	MEDICAL BIOCHEMISTRY	P
PHYSIOL	M121	PHYSIOLOGY	HP
ANAT/CE	M103	NEUROANATOMY	P
MED SCH	M117	FCC 1	P
		(GRADED PASS/FAIL ONLY)	
ANAT/CE	M135	SECT ANAT BASIS COMP MOD	CR
INT MED	M190	THRILLS/SPILLS EMERG MED	CR
FALL 2002		MEDICAL	
MICROBI	M212	MICROBIOLOGY-IMMUNOLOGY	H
MED SCH	M214	FCC 2	P
		(GRADED PASS/FAIL ONLY)	
SPRING 2003		MEDICAL	
PATH LA	M210	PATHOLOGY	H
PHARM-M	M216	PHARMACOLOGY	HP
INT MED	M218	PATHOPHYSIOLOGY	P
INT MED	M222	FUNDAMENTALS CL CARE 202	P
		(GRADED PASS/FAIL ONLY)	
PSYCHIA	M224	BEHAVIORAL MEDICINE	P
INT MED	M226	EPIDEMIOLOGY	H
FALL 2003		MEDICAL	
INT MED	M315	MEDICINE	HP
FAM/CMT	M360	FAMILY PRACTICE	H
PEDIAT	M330	PEDIATRICS	H
SPRING 2004		MEDICAL	
SURGERY	M355	SURGERY	H
OB/GYN/	M321	OBSTETRICS / GYNECOLOGY	H
PSYCHIA	M342	PSYCHIATRY	H
ANESTH	M380	ANESTHESIOLOGY	P
		(GRADED PASS/FAIL ONLY)	
FALL 2004		MEDICAL	
EMERG M	M425	EMERGENCY MEDICINE	H
NEUROL	M602	NEUROSCIENCE	H
FAM/CMT	M441	FAMILY PRAC RESID SITES	H
INT MED	M856	MED SUBINTERNSHIP	HP
INT MED	M521	INFECTIOUS DISEASES	H
RADIOLO	M727	DIAGNOSTIC RADIOLOGY	HP
SPRING 2005		MEDICAL	
INT MED	M477	CARDIOLOGY	P
MED SCH	M905	INTERNATIONAL MED ELECT	H
INT MED	M533	MEDICAL ICU	P
** END DOCUMENT **			

MEMORANDA

MED SCH ADMISSION
FALL 2001

PASSED USMLE STEP 1
SPRING 2003

PASSED USMLE STEP2CK
FALL 2004

PASSED USMLE STEP2CS
FALL 2004

RECEIVED
MAY 0 1 2007
DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

Jane E. Stringer
DIRECTOR
OFFICE OF STUDENT RECORDS

DEPARTMENT | COURSE | COURSE TITLE | GRD

TEMPLE UNIVERSITY

OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION
SCHOOL OF MEDICINE
PHILADELPHIA, PENNSYLVANIA 19140

GRADING SYSTEM		
GRADE	LETTER DESIGNATION	COMMENT
HONORS	H	A CLEARLY SUPERIOR PERFORMANCE THAT REFLECTS EXCEPTIONAL ACHIEVEMENT OF COURSE OBJECTIVES AND ASSIMILATION OF ADDITIONAL MATERIAL.
HIGH PASS	HP	A PERFORMANCE BEYOND COURSE REQUIREMENTS.
PASS	P	A SATISFACTORY PERFORMANCE THAT MEETS ALL BASIC COURSE REQUIREMENTS.
CREDIT	CR	A PASSING GRADE FOR INDEPENDENT STUDIES AND FOR ELECTIVES IN YEARS ONE AND TWO.
CREDIT BY EXEMPTION	CE	A PASSING GRADE GRANTED FOR PRIOR EXPERIENCE ACCEPTED IN LIEU OF STANDARD COURSE WORK.
CONDITION	*C*	*A PERFORMANCE LESS THAN, BUT CLOSE TO, ACCEPTABLE MINIMUM STANDARDS. (GRADE DISCONTINUED EFFECTIVE FALL 2005)*
FAIL	F	A PERFORMANCE WELL BELOW ACCEPTABLE MINIMUM STANDARDS.
INCOMPLETE	I	A TEMPORARY GRADE INDICATING THAT A STUDENT HAS BEEN UNABLE TO COMPLETE ALL COURSE REQUIREMENTS FOR REASON(S) BEYOND HIS/HER CONTROL.
(GRADES ASSIGNED BY SCHOOL OF MEDICINE ADMINISTRATION ONLY)		
NO GRADE REPORTED	NR	
WITHDREW	W	WITHDREW FROM SCHOOL BEFORE COMPLETION OF COURSE.
APPLIED CREDIT		*(GRADE DISCONTINUED EFFECTIVE FALL 2004)*

TO TEST FOR AUTHENTICITY: Translucent globe icons *MUST* be visible from both sides when held toward a light source. The face of this transcript is printed on green SCRIP-SAFE® paper with the name of the institution appearing in small print over the face of the entire document.

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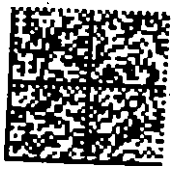
06195906 SCRIP-SAFE ® Security Products, Inc. Cincinnati, OH•U.S. Patent **5,171,040**

School of Medicine
TEMPLE UNIVERSITY

Office of Student Records
3420 North Broad Street
Medical Research Building, Room 106
Philadelphia, PA 19140



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

9650437666 B001

TEMPLE UNIVERSITY

OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION
SCHOOL OF MEDICINE
3400 NORTH BROAD STREET
PHILADELPHIA, PENNSYLVANIA 19140

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PAGE 01 OF 01
DATE 05/26/05
TIME 03:26 PM

KOVICH, HEATHER C

STUDENT ID
2 - DOH Licensee So...
00849358

COLL MEDICAL
CURR MEDICINE

RECEIVED
MAY 31 2005
DEPARTMENT OF HEALTH
HEALTH PROFESSIONS

PROFESSIONAL MEDICAL EXTRACT

MD AWARDED 05/2005
COLLEGE: MEDICAL CURRICULUM: MEDICINE

DEPARTMENT	COURSE	COURSE TITLE	CREDITS	GRD	SYM
FALL 2001		MEDICAL			
ANAT/CE	M101	GROSS ANATOMY		P	
ANAT/CE	M102	HISTOLOGY		HP	
ANAT/CE	M104	EMBRYOLOGY		P	
PSYCHIA	M113	BEHAVIORAL SCIENCE		HP	
SPRING 2002		MEDICAL			
BIOCHEM	M119	MEDICAL BIOCHEMISTRY		P	
PHYSIOL	M121	PHYSIOLOGY		HP	
ANAT/CE	M103	NEUROANATOMY		P	
MED SCH	M117	FCC 1		P	
		(GRADED PASS/FAIL ONLY)			
ANAT/CE	M135	SECT ANAT BASIS COMP MOD		CR	
INT MED	M190	THRILLS/SPILLS EMERG MED		CR	
FALL 2002		MEDICAL			
MICROBI	M212	MICROBIOLOGY-IMMUNOLOGY		H	
MED SCH	M214	FCC 2		P	
		(GRADED PASS/FAIL ONLY)			
SPRING 2003		MEDICAL			
PATH LA	M210	PATHOLOGY		H	
PHARM-M	M216	PHARMACOLOGY		HP	
INT MED	M218	PATHOPHYSIOLOGY		P	
INT MED	M222	FUNDAMENTALS CL CARE 202		P	
		(GRADED PASS/FAIL ONLY)			
PSYCHIA	M224	BEHAVIORAL MEDICINE		P	
INT MED	M226	EPIDEMIOLOGY		H	
FALL 2003		MEDICAL			
INT MED	M315	MEDICINE		HP	
FAM/CMT	M360	FAMILY PRACTICE		H	
PEDIAT	M330	PEDIATRICS		H	
SPRING 2004		MEDICAL			
SURGERY	M355	SURGERY		H	
OB/GYN/	M321	OBSTETRICS / GYNECOLOGY		H	
PSYCHIA	M342	PSYCHIATRY		H	
ANESTH	M380	ANESTHESIOLOGY		P	
		(GRADED PASS/FAIL ONLY)			
FALL 2004		MEDICAL			
EMERG M	M425	EMERGENCY MEDICINE		H	
NEUROL	M602	NEUROSCIENCE		H	
FAM/CMT	M441	FAMILY PRAC RESID SITES		H	
INT MED	M856	MED SUBINTERNSHIP		HP	
INT MED	M521	INFECTIOUS DISEASES		H	
RADIOLO	M727	DIAGNOSTIC RADIOLOGY		HP	
SPRING 2005		MEDICAL			
MED SCH	M905	INTERNATIONAL MED ELECT		H	

** END DOCUMENT **

MEMORANDA

MED SCH ADMISSION
FALL 2001

PASSED USMLE STEP 1
SPRING 2003

PASSED USMLE STEP2CK
FALL 2004

PASSED USMLE STEP2CS
FALL 2004

TEMPLE UNIVERSITY
Incorporated May 12, 1888
Philadelphia
Commonwealth System of Higher Education

M. Judith Russo
Administrative Director
Office of the Dean

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DEPARTMENT | COURSE | COURSE TITLE | CREDITS | GRD | SYM

TEMPLE UNIVERSITY

OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION
SCHOOL OF MEDICINE
PHILADELPHIA, PENNSYLVANIA 19140

GRADING SYSTEM

FOR ADDITIONAL INFORMATION SEE TEMPLE UNIVERSITY SCHOOL OF MEDICINE **GRADING AND PROMOTIONAL POLICIES**.

GRADE	LETTER DESIGNATION	COMMENT
HONORS	H	A CLEARLY SUPERIOR PERFORMANCE THAT REFLECTS EXCEPTIONAL ACHIEVEMENT OF COURSE OBJECTIVES AND ASSIMILATION OF ADDITIONAL MATERIAL.
HIGH PASS	HP	A PERFORMANCE BEYOND COURSE REQUIREMENTS.
PASS	P	A SATISFACTORY PERFORMANCE THAT MEETS ALL BASIC COURSE REQUIREMENTS.
CREDIT	CR	A PASSING GRADE USED FOR ALL ELECTIVE COURSES OF THE FIRST AND SECOND YEARS.
CREDIT BY EXEMPTION	CE	A PASSING GRADE GRANTED FOR PRIOR EXPERIENCE ACCEPTED IN LIEU OF STANDARD COURSE WORK.
CONDITION	C	A PERFORMANCE LESS THAN, BUT CLOST TO, ACCEPTABLE MINIMUM STANDARDS.
FAIL	F	A PERFORMANCE WELL BELOW ACCEPTABLE MINIMUM STANDARDS.
INCOMPLETE	I	A TEMPORARY GRADE INDICATING THAT A STUDENT HAS BEEN UNABLE TO COMPLETE ALL COURSE REQUIREMENTS FOR REASON(S) BEYOND HIS/HER CONTROL.
(GRADES ASSIGNED BY SCHOOL OF MEDICINE ADMINISTRATION ONLY)		
NO GRADE REPORTED	NR	
WITHDREW	W	WITHDREW FROM SCHOOL BEFORE COMPLETION OF COURSE.

TO TEST FOR AUTHENTICITY: Translucent globe icons *MUST* be visible from both sides when held toward a light source. The face of this transcript is printed on green SCRIP-SAFE® paper with the name of the institution appearing in small print over the face of the entire document.

TEMPLE UNIVERSITY SCHOOL OF MEDICINE • TEMPLE UNIVERSITY SCHOOL OF MEDICINE • TEMPLE UNIVERSITY SCHOOL OF MEDICINE • TEMPLE UNIVERSITY SCHOOL OF MEDICINE•TEMPLE UNIVERSITY SCHOOL OF MEDICINE•TEMPLE UNIVERSITY SCHOOL OF MEDICINE•TEMPLE UNIVERSITY SCHOOL OF MEDICINE • TEMPLE UNIVERSITY SCHOOL OF MEDICINE • TEMPLE UNIVERSITY SCHOOL OF MEDICINE • TEMPLE UNIVERSITY SCHOOL

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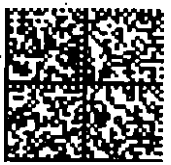
04225304 SCRIP-SAFE ® Security Products, Inc. Cincinnati, OH•U.S. Patent **5,171,040**

TEMPLE UNIVERSITY
A Commonwealth University

School of Medicine

Office of Student Records
3400 North Broad Street
Philadelphia, Pennsylvania 19140



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

Department of Health

MD

TO: Post Graduate Training Program Director

RECEIVED

JUN

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5

FACILITY NAME: FAMILY MEDICINE RESIDENCY PROGRAM
UWMC AT ROOSEVELT

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

RE: Verification/Evaluation of Training

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

HEATHER KOVICH
APPLICANT (PRINT OR TYPE)

3/7/77
BIRTHDATE

SIGNATURE OF APPLICANT

1. HEATHER KOVICH is or was engaged in postgraduate training in our program

from 6/25/05 (BEGINNING DATE (MONTH & YEAR)) to 6/30/08 (ENDING DATE (MONTH & YEAR))

in the field of FAMILY MEDICINE.

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
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(SEAL)

Signature

Title PROGRAM DIRECTOR
PLEASE TYPE OR PRINT

Hospital FAMILY MEDICINE RESIDENCY PROGRAM

Address UWMC AT ROOSEVELT
4245 ROOSEVELT WAY NE, BOX 354775
SEATTLE, WA 98105

Date 5/25/07

Telephone 206 598 2883

DOH 657-034 (REV 6/2006)

Montana Board of Medical Examiners

301 S. Park Avenue
PO BOX 200513
Helena MT 59620-0513
(406) 841-2362 or 841-2364

License Verification as of July 24, 2007

TO WHOM IT MAY CONCERN:

I do certify that a standard search of available records of the office of the Montana Board of Medical Examiners indicates the following:

Licensee Name:	HEATHER C KOVICH
Mailing Address:	1020 IDAHO
	LIBBY, MT 59923
License Type:	
License Number:	11141
Original License Date:	07/24/2006
Licensure Method:	Endorsement
License Status:	Active Temporary
Expiration Date:	10/24/2006
Also Known As:	

This license information was last updated on: 07/24/2007

Our records show no adverse information concerning this licensee.

We cannot guarantee the accuracy of disciplinary actions occurring prior to this date. However, every reasonable effort has been made to provide complete and accurate information.

Acting on behalf of the Montana Board of Medical Examiners.

Jeannie R. Worsech
Executive Director
Montana Board of Medical Examiners

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 CLEARANCE REPORT

April 13, 2007

Attn: Blake Maresh, MPA
Washington Md.Quality Assur Commission
310 Israel Road SE
PO Box 47865
Tumwater, WA 98501

Re: Board Action Query Dated: April 13, 2007
Your Reference Number:
FSMB Batch Number: BQ1341135

The following is a report of the search results from the Board Action Data Bank as of April 13, 2007 for practitioners submitte referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 13, 2007

Item	Name	DOB	School	Yr/Grad
3	Agbo, Osmund	11/17/1969	690055	1997
4	Albaquib, Nawar	02/01/1945	528010	1968
2	Anselmetti, Monica	08/09/1964	043020	2003
1	Antia, Nevilla	08/26/1974	661030	2005
9	Barr, Carmela	02/20/1955	014040	1979
8	Best, Gail	10/22/1962	023010	1994
5	Bigosinski, Krystian	06/11/1978	014040	2001
6	Bobba, Swapna	11/05/1972	495090	1996
10	Butani, Raj	09/11/1972	039100	1996
39	Chattin, Elizabeth	12/13/1948	099691	2005
45	Cheekatla, Suresh	05/02/1980	495180	2002
11	Claud, Jonathan	11/30/1973	014040	2002
13	Coots, Bradley	05/09/1969	014080	2001
15	Dogra, Vivek	06/23/1964	495237	1989
16	Dombrowski, Julia	03/31/1976	034020	2004
44	Fallahian, Amir	09/21/1973	517060	1998
17	Fong, Abraham	10/11/1976	039040	2004
40	Fucci, Christopher	11/01/1971	099561	1998
18	Gallardo, Kathy	01/05/1962	005020	2001
42	Garvin, Kanishka	05/08/1981	001010	2007
43	Ghavami, Parham	02/03/1965	422010	1998
20	Grathwohl, Kurt	11/22/1965	021030	1991
23	Hagen, Christopher	08/24/1973	048010	2003
22	Hammar, Ned	03/28/1975	021010	2005
24	Hoover, Mark	11/30/1974	005060	2001
25	Hunt, Aaron	11/14/1969	026050	2003
28	Jacobson, Elizabeth	12/13/1978	024010	2004
31	Karis, Elaine	09/27/1977	033110	2004
32	Kishiyama, Christopher	04/20/1970	006010	2000
30	Kovich, Heather	03/07/1977	039080	2005
46	Leblond, Antoine	04/29/1978	064010	2007

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

HEATHER CLARE KOVICH MD

1 - DOH Licensee Health Profession...

Primary Office Address:

BOX 354775
4245 ROOSEVELT WAY NE
SEATTLE WA 98105-6008

Phone: UNKNOWN

Birthdate: 03/07/1977
Birthplace: PHILADELPHIA, PA UNITED STATES OF AMERICA

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

Practice Specialties Self Designated by the Physician*:

Primary Specialty: FAMILY MEDICINE

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:

TEMPLE UNIV SCH OF MED, PHILADELPHIA PA 19140

Degree Awarded: Yes

Degree Year: 2005

AMA AMERICAN MEDICAL ASSOCIATION

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: UNIV OF WA SCH OF MED
Specialty : FAMILY MEDICINE

State: WASHINGTON
06/2005 - 06/2008
(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.**

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
MONTANA	MD	07/24/2006	10/24/2006	ACTIVE	RESIDENT	11/14/2006
WASHINGTON	MD	06/24/2005	07/31/2007	ACTIVE	LIMITED	03/16/2007

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

ECFMG Certfication:

Applicant Number:

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

Federal Drug Enforcement Administration:

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

DEA Number *	Schedule	Expiration Date	Last Reported
XXXXXX091	22N 33N 4 5	12/31/2008	03/06/2007

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
AMERICAN
MEDICAL
ASSOCIATION

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: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:

Duration	Effective	Expiration	Occurrence	Last Reported

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.**

Medicare/Medicaid Sanction(s):

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

Other Federal Sanction(s):

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

AMA
AMERICAN
MEDICAL
ASSOCIATION

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.

Medical Quality Assurance Commission
Limited License Application Worksheet

Name KOVICH HEATHER Date of Birth 3/7/1977

Date Received 5/17/2005 Cash Number 05139198 / Candidate Number

x	WSP Check	x	Fee	x	Photo	x	Data1-13	x	AIDS	x	Attest	x	SSN		Garfield Search

Chronology Complete [ ]

Missing: ____ to ____; ____ to ____; ____ to ____

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

[6/9] FSMB [ ] AMA

Personal Data "Yes"s	Documentation Received

Malpractice Cases

	Synopsis	Disposition
1		
2		
3		
4		

Medical School Name TEMPLE School Code ____ Year of Degree 2005

[ ] U.S. [ ] Canadian [ ] International

5/31/05 Transcripts [ ] Translations

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

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

Received	State Licensure	Received	Hospital Privileges

Received	Program/Employment Verification	Received	Program/Employment Verification
5/27/05	U OF WASHINGTON 6/30/2005		

Approved [signature] Signature 6-21-2005 Date

Comments:

Deficiency Letters:

[ ]	January	[ ]	April	[ ]	July	[ ]	October	[ ]	
[ ]	February	[ ]	May	[ ]	August	[ ]	November	[ ]	
[ ]	March	[ ]	June	[ ]	September	[ ]	**December**	[ ]	

Washington State Department of Health

R04

225

LIMITED PHYSICIAN

REVENUE SECTION

PRINT NAME Kovich, H.

LF 0252140000 aaa3s

001981 05/19/2005 22500

Health

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

BACKGROUND CHECK PROCESSED

MAY 17 2005

Department of Health
Investigation Service Unit

FOR OFFICE USE ONLY	
ISSUANCE DATE	
LICENSE #	8243

LICENSE #

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

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

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

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

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL
KOVICH	HEATHER	C

NAME OF INSTITUTION/HEALTH DEPT./MEDICAL SCHOOL/HOSPITAL

ADDRESS

CITY	STATE	ZIP	COUNTY

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)
(267) 879-3710	2 - DOH Licensee Social Security Number - RCW 42....

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
☒ Female ☐ Male	03/07/77	Philadelphia, 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"	130
EYE COLOR	**HAIR COLOR**
grey	brown

MEDICAL SCHOOL	YEAR OF GRADUATION
Temple Univ. S.O.M	2005

MEDICAL SPECIALITY

Heather Kovich 5/6/05

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?	☐	☑
11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☑
12. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☑
13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☑

3. Education And Experience

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

SCHOOLS ATTENDED (LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.)	NUMBER OF YEARS ATTENDED	DATES ATTENDED FROM (MO/YR)	DATES ATTENDED TO (MO/YR)	DIPLOMA OR DEGREE OBTAINED (QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.)
Medical Education (List all Medical Schools Attended)				
Temple University S.o.M	4	8/01	5/05	MD
Post-Graduate Training (List all Programs Attended)				

4. Professional Experience

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

	DATES OF EXPERIENCE FROM (MO/YR)	DATES OF EXPERIENCE TO (MO/YR)

5. Hospital Privileges

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

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	DATES BEGINNING (MO/YR)	DATES ENDING (MO/YR)

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	
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ 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)

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	DATE
HK	4/24/05

9. Applicant's Attestation

I, Heather Kovich, certify that I am the person described and identified
NAME OF APPLICANT

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.

Heather Kovich
SIGNATURE OF APPLICANT

4/24/05
DATE

Official Use Only

Washington State Records Center

Health
Medical Quality Assurance Commission
PO Box 47866
Olympia WA 98504-7866
(360) 753-2844
(360) 664-8689

LMT

Medical Quality Assurance Commission

Residency Certification

This is to certify that HEATHER KOVICH, M.D. has been

appointed as a resident* in FAMILY MEDICINE (SERVICE) at

the FAMILY MEDICINE RESIDENCY PROGRAM
UWMC AT ROOSEVELT
4245 ROOSEVELT WAY NE, BOX 354775
SEATTLE, WA 98105
hospital for the period

beginning 6 - 24 - 2005 (MONTH / DAY / YEAR). The individual responsible for this resident's patient care activities

will be _____ (SIGNATURE) DIRECTOR OF PROGRAM.

*Residents 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)

DOH 657-057 (REV 10/2003)

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 CLEARANCE REPORT

June 09, 2005

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

Re: Board Action Query Dated: June 09, 2005
Your Reference Number:
FSMB Batch Number: BQ1146021

The following is a report of the search results from the Board Action Data Bank as of June 09, 2005 for practitioners submitte referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of June 09, 2005

Item	Name	DOB	School	Yr/Grad
1	Antia, Neville	08/26/1974	661030	2005
2	Balakrishnan, Karthik	07/16/1977	021010	2005
4	Cooke, Erin	02/27/1979	044010	2005
5	Cooper, Ellen	07/31/1978	033090	2005
6	Hammar, Ned	03/28/1975	021010	2005
8	Hicks, Raegan	06/23/1978	022010	2005
9	Hidalgo, Josephine	01/28/1979	026060	2005
10	Jain, Shamik	02/04/1979	021010	2005
11	Jensen, Christine	12/19/1978	048010	2004
13	Kovich, Heather	03/07/1977	039080	2005
14	Lacey, Benjamin	08/15/1978	016010	2005
16	Little, Malaika	09/25/1975	046010	2005
3	chiu, Lynn	09/18/1978	005020	2005

telnet (GothomCity)

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                      AAAAAA     SSSSSS    IIIIIIIIII
                     AAAAAAA    SSS  SSS   IIIIIIIIII
                    AAAAAAAA   SSS    SSS      III
MEDICAL BOARD            ASSESSMENT SYSTEMS, INC.                  06-10-05
bje1303                        REAL SYSTEM          V2.5.74        08:10:58 AM
INDIVIDUAL NAME                 (JR,SR,III)          REFERENCE # CA00007570
   LAST KOVICH                                       SOC SEC NUM [2 - DOH Licensee Soci...]
  FIRST HEATHER                 +-ADDITIONAL INFORMATION----------------+
 MIDDLE C                       |          SEX F =      MARRIED N =      |
                                |                                        |
RESIDENCE INFORMATION            |   OTHER NAME                           |
UNIVERSITY OF WASHINGTON         |CORP. OFFICER                         = |
BOX 356340                       |TRUST ACCOUNT                           |
SEATTLE WA 98195                 |                                        |
                                 |  BIRTH PLACE PHILADELPHIA PA           |
                                 |        DATE 03-07-1977                 |
PHONE: (   )    -      COUNTY:   17                                       |
       (   )    -      LGL ST:          |SCHOOL CODE 039080                 |
                                 |   CE UNITS    0.00 REQD BY   -  -      |
NOTES                            +----------------------------------------+

+-------------------------------------------------------------------------+
|CURRENT STATUS: U    EXPIRATION DATE:   -  -      FIRST ISSUE DATE:   -  -  |
|RENEWAL STATUS:     LAST ACTIVE DATE:   -  -     LAST RENEWAL DATE:   -  -  |
|COMPLAINTS O/C:  0/ 0      AUTHORITY:                                    |
+-------------------------------------------------------------------------+
1MENU #1  2ADDR DAT 3  ALIAS  4NAME HIS 5         6         7         8FILL BRN
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STATE OF WASHINGTON
DEPARTMENT OF HEALTH

April 19, 2007

Heather Kovich MD

1 - DOH Licensee Health Prof...

Dear Dr Kovich

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

Your application and fee of $135.00 was received on April 12 2007

MISSING ITEMS
Post Graduate Training Verification submit after completing 24 months
State License Verification MT

.A deficiency letter, if that is what you have chosen, will be sent about every four to six weeks until the application is considered complete. Please understand deficiency letters are our way of notifying you what is lacking in your file. **If you choose to use email as your way of checking on your application, that may be done at any time.**

Please note: while this information was contained in the application packet you had been sent and is stipulated in Washington Administrative Code (WAC) 246-12-020(3), let me reiterate that upon approval, your initial license will be issued *only* to your next birthday after the approval date – unless your birthday falls within 90 days of approval, in which case it will expire on your second birthday following approval.

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

Sincerely

Betty Elliott, Licensing **Representative**

Application File_549621_pdf-r.pdf redacted on: 7/29/2015 08:08

Redaction Summary (11 redactions)

2 Privilege / Exemption reasons used:

1 -- "DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2)" (5 instances)

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

Page 1, DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2), 1 instance
Page 1, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 5, DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2), 2 instances
Page 5, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 11, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 14, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 20, DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2), 1 instance
Page 27, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 33, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 34, DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2), 1 instance