Medical Quality Assurance Commission
Limited License Application Worksheet

Name ALTSHULER, ANNA Date of Birth 02/15/1981

Date Received 4/23/09 Cash Number _____ Candidate Number _____

x	WSP Check	x	Fee	x	Photo	x	Data1-13	x	AIDS	x	Attest		SSN		FBI

Chronology
Complete _____ to _____

☐ Residency ☐ Institution
☐ Fellowship ☐ City/County
☐ Teaching/Research

5/12/09 FSMB

☐ AMA

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

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

Name U OF CALIFORNIA Year of Degree 2009 ☐ 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

4/23/09	U OF WASHINGTON 6/25/09 ✓		

Beverly Lee 6/9/10

Deficiency Letters:

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

Washington State Department of Health

385

LOG

LIMITED PHYSICIAN

REVENUE SECTION

PRINT NAME Altshuler, Anna

1F 0252140000 00335

"0449"

0449-4/23/2009 9:31:34 AM-601 $385.00

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
A-L 360.236.2766
M-Z 360.236.2765

Background Check Processed
MAY 08 2009
NPDB/HIPDB
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

RECEIVED
APR 29 2009
DEPARTMENT OF HEALTH
MEDICAL COMMISSION
LOG

Revenue 0252140000

Limited Physician & Surgeons License Application

☒ Resident Physician ☐ Teaching/Research ☐ Institutional
☐ Fellowship (2 year limit) ☐ County/City Health Department

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)
2 - DOH Licensee Social Security Number - RCW 42.56....

☐ Male ☒ Female

Name	First	Middle	Last
	Anna	Lea	Altshuler

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country
02/15/1981	Moscow		Russia

Address: 948 19th St Apt #5

City	State	Zip	County
Santa Monica	CA	90403	Los Angeles

Country: USA

Phone (1 - DOH Licensee Health Professional ...) Fax ( ) Cell 1 - DOH Licensee Health Professional Home Ad...

Email address: ala05@u.washington.edu

Mailing address (if different from above)

City	State	Zip	County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☒ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☒ No

If yes, list name(s):

Medical Specialty

Medical school	Year of Graduation
University of California, Irvine School of Medicine	2009
Medical Specialty	**Date Issued**
Obstetrics/gynecology	

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 attach explanation. ☐ ☒

   "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.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

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

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☒

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

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to 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, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☒

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☒

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding 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?	☐	☒
b. Diverted controlled substances or legend drugs?	☐	☒
c. Violated any drug law?	☐	☒
d. Prescribed controlled substances for yourself?	☐	☒
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", please attach an explanation 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?	☐	☒
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☒
10. 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?	☐	☒
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☒
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☒
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☒
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☒

3. Medical Education and Experience

Provide a chronological listing of your educational preparation and post-graduate training. If you need more space, attach a piece of paper.

Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Diploma or degree obtained (Quote titles in original language and translate to English.)	Number of years attended	Dates granted	
			Start (mm/yyyy)	End (mm/yyyy)
Medical education (list all medical schools attended)				
University of California, Irvine	MD	4	06/2004	06/2009
Post graduate training (list all programs attended)				
N/A				

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. If you need more space, attach a piece of paper. none

Name and location of institution	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Nature of experience or specialty

5. Hospital Privileges (Excluding post-graduate training hospital privileges.)

Excluding post-graduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper. none

Name of hospital	Dates attended		
	Start date mm/dd/yyyy	End date mm/dd/yyyy	

6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. List in chronological order, starting with the most current.

State	Date license issued	License Number	Basis of License		Status of license	Any limitations on license
			Exam date passed	Endorsement		
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four (4) of education in the prevention, transmission, and treatment of AIDS. This education included topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

Applicant's initials	Date
ALA	3/25/2009

8. Applicant's Photograph

Photo Here

Height 5'5"

Weight 140 lb

Hair color brown

Color of eyes brown

9. Applicant's Attestation

I, Anna Altshuler , declare under penalty of perjury under the
(Print applicant name clearly)

laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated 3/25/2009 at Santa Monica, CA (city, state)

By: Anna Altshuler
Signature of applicant

2 - DOH Licensee...

59338-795 G ALTSHULER,ANNA LEA *MEDICINE *MEDICINE

RESIDENT SEP 2004 MOSCOW, RUSSIA 02/15/XX GRADUATE

CFC 08/24/09 08/25/09

- PREVIOUS DEGREES -
BA-MO&CEL BIO UC BERKELEY 12/2003

- DOCTORS DEGREES -
DEGREE CONFERRED - MEDICAL DOCTOR
JUNE 13, 2009

SUMMER QUARTER 2004

LATIN AMERICAN LC&H	MED ED	549	24.0	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

FALL QUARTER 2004

HISTOLOGY	ANATOMY	503A	1.9	P	PF
MEDICAL BIOCHEM	BIOCHEM	522	5.1	P	PF
MOLEC & CELL BIO	BIOCHEM	523	7.2	P	PF
PT-DR & SOCIETY	ED AFF	545	5.4	P	PF
PATIENT DOCTOR	MED ED	546A	1.5	H	PF
MEDICAL GENETICS	PEDS	511	3.9	P	PF
PHYSIO/PATHOPHYSIO	PHYSIO	543A	2.0	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

WINTER QUARTER 2005

ANATOMY/EMBRYOLOGY	ANATOMY	500A	14.5	P	PF
HISTOLOGY	ANATOMY	503B	3.5	P	PF
PATIENT DOCTOR	MED ED	546B	7.7	H	PF
PHYSIO/PATHOPHYSIO	PHYSIO	543B	11.5	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

SPRING QUARTER 2005

ANATOMY/EMBRYOLOGY	ANATOMY	500B	5.4	P	PF
IMMUNOLOGY	MIC BIO	544	5.0	P	PF
PATIENT DOCTOR	MED ED	546C	2.4	H	PF
NEUROSCIENCE	PHYSIO	502A	9.6	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0
0.0* ATTM 0.0* PSSD 0.0* G.P.			0.0 BAL		0.000 GPA

FALL QUARTER 2005

TOPICS IN MEDICINE	INT MED	515A	2.3	P	PF
MED MICROBIOLOGY	MIC BIO	507A	7.1	P	PF
PATIENT DOCTOR	MED ED	546D	4.8	H	PF
GEN & SYS PATHOLOGY	PATH	508B	6.2	P	PF
MED PHARM	PHARM	517A	5.0	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

WINTER QUARTER 2006

TOPICS IN MEDICINE	INT MED	515B	4.0	P	PF
PATIENT DOCTOR	MED ED	546E	5.5	H	PF
GEN & SYS PATHOLOGY	PATH	508B	6.2	P	PF
CLINICAL PATHOLOGY	PATH	509A	5.3	P	PF
MED PHARM	PHARM	517B	1.8	P	PF
CUL HI LAT MD CARE	MED ED	552A	8.0	H	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

SPRING QUARTER 2006

EPI/BIO STATS	CEM	548	2.0	P	PF
TOPICS IN MEDICINE	INT MED	515C	4.1	P	PF
PATIENT DOCTOR	MED ED	546F	5.3	H	PF
GEN & SYS PATHOLOGY	PATH	508C	3.1	P	PF
MED PHARM	PHARM	517C	4.0	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0
0.0* ATTM 0.0* PSSD 0.0* G.P.			0.0 BAL		0.000 GPA

SUMMER QUARTER 2006

CLINICAL FOUNDATION	INT MED	550	4.0	P	PF
SURGERY CLERKSHIP	SURGERY	526	32.0	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

FALL QUARTER 2006

OB/GYN CLERKSHIP	OB/GYN	524	32.0	H	PF
LATINO MEDICAL CARE	MED ED	553A	0.4	H	PF
PSYCHIATRY CLERKSHP	PSYCH	529	24.0	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

WINTER QUARTER 2007

INPATIENT MEDICINE	INT MED	527A	32.0	P	PF
PEDIATRIC CLERKSHIP	PEDS	528	32.0	H	PF
LATINO MEDICAL CARE	MED ED	553B	4.0	H	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

SPRING QUARTER 2007

FAMILY MED CLERK	FAM MED	597A	16.0	H	PF
AMBULATORY MEDICINE	INT MED	527B	16.0	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0
0.0* ATTM 0.0* PSSD 0.0* G.P.			0.0 BAL		0.000 GPA

SUMMER QUARTER 2008

HEART STATION	INT MED	630B	8.0	H	PF
INFECTIOUS DISEASES	INT MED	633K	8.0	H	PF
EXTRAMURAL-OB/GYN	OB/GYN	6930	16.0	H	PF
EXTRAMURAL-OB/GYN	OB/GYN	6930	16.0	H	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

FALL QUARTER 2008

SURGICAL ANATOMY	ANATOMY	600L	8.0	H	PF
MED SUBI UCIMC	INT MED	536	16.0	H	PF
HIGH-RISK OBSTETRIC	OB/GYN	645F	16.0	H	PF
EXTRAMURAL-OB/GYN	OB/GYN	6930	12.0	H	PF
SUBSTANCE ABUSE	PSYCH	675A	8.0	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

WINTER QUARTER 2009

PULMONARY MICU	INT MED	630K	16.0	P	PF
ADV PATIENT-DOCTOR	MED ED	535	10.0	P	PF
CORE NEURO AWAY	NEUROL	694N	16.0	H	PF
TERM TOTALS: 0.000 GPA			0.0		0.0

SPRING QUARTER 2009

ER MED CLERKSHIP	ER MED	547	8.0	P	PF
RADIOLOGY CLERK	RADIO	533	8.0	P	PF
TERM TOTALS: 0.000 GPA			0.0		0.0
0.0* ATTM 0.0* PSSD 0.0* G.P.			0.0 BAL		0.000 GPA

0.0* ATTM 0.0* PSSD 0.0* G.P. 0.0 BAL

QUARTER CREDITS COMPLETED 543.7 UC GPA 0.000

University of California, Irvine
College of Medicine

Legend

Course Hours = Credits x 10

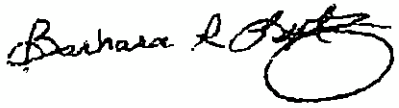
Grade	
H	Honors
P	Pass
F	Failure
I	Incomplete
IP	In Progress
NR	No Report

THIS IS AN OFFICIAL TRANSCRIPT
OF RECORD

Barbara R. Lutz
Assistant Registrar
UCI College of Medicine

Barbara R. Lutz

* Effective Fall 1994



UNIVERSITY OF CALIFORNIA, IRVINE
SCHOOL OF MEDICINE
EDUCATIONAL AFFAIRS
OFFICE OF STUDENT AFFAIRS
BERK HALL, BUILDING 802
IRVINE, CA 92697-4089

ANNA LEA ALTSHULER, M.D.

Official Transcript

Educational Aff
UC Irvine Schoo
Irvine, CA 9269

Hasler

016H26520175
$00.88
09/03/2009
Mailed From 92697
US POSTAGE

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

Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
A-L 360.236.2766
M-Z 360.236.2765

LMT

Medical Quality Assurance Commission

Resident Physician Limited License

This certifies the appointment of the following individual who is being recommended for a limited license in Washington State.

Name of Resident Physician: * Anna Altshuler

Name of training program/specialty: Obstetrics and Gynecology

Name of sponsoring institution: University of Washington

Beginning date 06/25/2009
mm/dd/yyyy

(Signature) Director of Program

Is this an ACGME Program? ..... Yes ☒ No ☐

* Resident physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.055 and is serving a period of post graduate 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.

Note: The issuance of a limited license does not allow the individual to engage in the practice of medicine outside the supervision of the post-graduate clinical medical training program.

HOSPITAL SEAL

DOH 657-057 (Rev. October 2008)

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

May 12, 2009

Attn: Maryella Jansen
Washington Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504

Re: Board Action Query Dated: May 12, 2009
Your Reference Number:
FSMB Batch Number: BQ1620067

The following is a report of the search results from the Board Action Data Bank as of May 12, 2009 for practitioners submitte referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 12, 2009

Item	Name	DOB	School	Yr/Grad	Request ID
7	Abelson, Jesse	08/25/1977	014060	2009	20824014
		LICENSE HISTORY State Board No License Information Available			
5	Adiarte, Eric	12/02/1980	024030	2009	20824005
		LICENSE HISTORY State Board No License Information Available			
1	Air, Mary	09/14/1982	007020	2009	20823985
		LICENSE HISTORY State Board No License Information Available			
4	Alexander, Jeremiah	08/22/1983	022010	2009	20824003
		LICENSE HISTORY State Board No License Information Available			
6	Altshuler, Anna	02/15/1981	005020	2009	20824010
		LICENSE HISTORY State Board No License Information Available			

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
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BOARD ACTION CLEARANCE REPORT

May 12, 2009

Attn: Maryella Jansen
Washington Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504

Re: Board Action Query Dated: May 12, 2009
Your Reference Number:
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Item	Name	DOB	School	Yr/Grad	Request ID
7	Abelson, Jesse	08/25/1977	014060	2009	20824014
		LICENSE HISTORY State Board No License Information Available			
5	Adiarte, Eric	12/02/1980	024030	2009	20824005
		LICENSE HISTORY State Board No License Information Available			
1	Air, Mary	09/14/1982	007020	2009	20823985
		LICENSE HISTORY State Board No License Information Available			
4	Alexander, Jeremiah	08/22/1983	022010	2009	20824003
		LICENSE HISTORY State Board No License Information Available			
6	Altshuler, Anna	02/15/1981	005020	2009	20824010
		LICENSE HISTORY State Board No License Information Available			

Elliott, Betty (DOH)

From: Elizabeth Jarrett [ejarrett@u.washington.edu]
Sent: Tuesday, June 02, 2009 10:19 AM
To: Elizabeth Jarrett; Elliott, Betty (DOH)
Subject: RE: licensing application

Hi Betty – I wonder if you could help me with something; I would be most grateful to you. The residency certification documents (of the limited license applications) for 6 of our new residents did not have a beginning date on them, although our program director, Dr Seine Chiang, had signed them. The beginning date of their residency should be 6/25/09. Will you take my email as sufficient documentation to make the correction on your end without having to fax back the documents to me? Here are the limited license applicants:

1. *Eric G Adiarte MD*
2. Meghan A McSorley MD MPH PhD
3. Dina M Gordon MD
4. Mary Tilley Jenkins Vogel MD
5. Andrew E Warner MD
6. Anna L Altshuler MD MPH

The beginning date of our new PGY2, Haider S Mahdi, MD, is 7/1/2009

From:
University of Washington School of Medicine
Departmetn of Obstetrics and Gynecology
Program Director: Seine Chiang MD

Thank you!
Elizabeth Jarrett
Residency Coordinator
206 543 9626 phone
206 543 3915 fax.

From: Elizabeth Jarrett
Sent: Thursday, May 28, 2009 11:15 AM
To: 'betty.elliott@doh.wa.gov'
Cc: 'dinamg@comcast.net'
Subject: *FW: licensing application*

Hi Betty – hope all is well and that you're hanging in there with the onslaught of resident licenses!
I wanted to double check your mailing address on your signature block- isn't your address PO Box 47866? One of our new residents was asking – the license itself shows 47866. Best wishes – Elizabeth Jarrett – UW Ob/Gyn.

From: dinamg@comcast.net [mailto:dinamg@comcast.net]
Sent: Thursday, May 28, 2009 11:12 AM
To: Elizabeth Jarrett
Subject: Fw: licensing application

Thanks for the confirmation...

-d.

Elliott, Betty (DOH)

To: ala05@u.washington.edu
Cc: Gabrielle N. Pett

May 13, 2009

Dear Dr Altshuler

This is to acknowledge receipt of your application to obtain a license for a **Residency** in the state of Washington.

Your application and fee of $385.00 was received on April 22 2009

MISSING ITEMS
Medical School Transcripts with MD degree

If you have any further questions or need additional information, please feel free to call me at (360) 236-4785, 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

Betty Elliott, Customer Service Specialist 2
Medical Quality Assurance Commission
WA State Department of Health
243 Israel Rd SE, Tumwater WA 98501
POB 7866, Olympia WA 98504
Email: betty.elliott@doh.wa.gov
Work Phone: 360 236-2766
Fax Number: 360 236-2795
Web Address:www.doh.wa.gov/medical

"The Department of Health works to protect and improve the health of the people of Washington State"

Credential View Screen [update]

Anna Lea Altshuler
Address:

(•) Public ( ) Mail ( ) Renewal Mail

[change public address]
Anna Lea Altshuler
University of Washington
Box 356340
Seattle, WA 98195

ID	912958
Warnings	
SSN/FEIN	2 - DOH License...
Contact Standing	Living
Contact Type	INDIVIDUAL
Birth Date	02/15/1981
Public File	**YES**
Mailing List	
Email:	**ala05@u.washington.edu**

Contact
Audit
Public Case
Cont. Edu
Documents
Owned By/
Exams
Experience
Notes
Schools
Supervises
Supervised
Librarian
Application
Other State

Comments:

Physician And Surgeon Residency License [update] [form letter]

Credential #	**MDRE.ML.60093363**	**Credential Status**	**PENDING** (05/07/2009)
Application Date	05/07/2009	Status Reason	INITIAL APPLICATION IN PROCESS
Effective Date		**Amount Due**	**$385.00**
Expiration Date		Date Last Activity	5/7/2009 3:47:16 PM
First Issuance Date		Last Updated by	Elliott, Betty
Last Date Of Contact	05/07/2009	Certificate Sent Date	
		Work Queue	Legacy, DOH

Auc
Doc
Wo
Key
Fee
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Comments:

User Defined License Data | **Legacy** | **HIPDB**

User Definable License Data [update]

Cash Receipt Sequence Number	00449
Cash Receipt Date	20090423
Cash Receipt Batch Number	0601

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MAY 11 2009
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Background Check Processed
[illegible] 2009
WSP
Department of Health
Investigation Service Unit

Application File_737608_pdf-r.pdf redacted on: 8/25/2016 10:50

Redaction Summary (5 redactions)

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2 Privilege / Exemption reasons used:

1 -- "DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2)" (2 instances)
2 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (3 instances)

Redacted pages:

Page 4, DOH Licensee Health Professional Home Address and/or Phone - RCW 42.56.350(2), 2 instances
Page 4, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 10, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 20, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance