THE NEW MEXICO MEDICAL SOCIETY

NMH&HSA
New Mexico Hospitals & Health Systems Association

cc $436.00

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The New Mexico Statewide Application for Physician/Practitioner Appointment©

Physician (MD) Application

(USING FCVS)

Date of Application: 12/1/10

Application Fee:	**400.00**
Background Check Fee:	**36.00**
TOTAL COST:	**$ 436.00**

Demographics

Name	Yonke (Last)	NICOLE (First)	JOY (Middle)

Other Names Used	Jonke - birth certificate only

Will you be applying by endorsement Yes ____ No X
(See page 2 of the application instructions for requirements)

Gender	M (F)	**Place of Birth**	California	**Citizenship**	USA
Immigration Status				**INS Certification #**	
***Social Security Number**	[redacted]			**Date of Birth**	[redacted]
***NM Tax ID# (if applicable)**	—		Pending ☐		
***Fed. Tax ID# (if applicable)**	—		Pending ☐		
Current Practice Name	None				
Practice Limited to: (Clinical Specialty)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
*Office Manager or Contact Person:					
Foreign Languages (spoken fluently by practitioner)					
Foreign Languages (spoken fluently at Practice)					
***E-Mail Address** (confidential)	[redacted]		@gmail.com		
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)					
*Street	[redacted]				
*City					97239
Telephone Number		Facsimile			
What are your immediate or future Practice Plans in New Mexico?	Maternal Child Health Fellowship at the University of New Mexico				
Home Address (Required)	*Telephone Number	[redacted]			
Street	[redacted]				
*City				*Zip	97239

*Information Confidential

Practice Associates in NM (If Applicable)	Call Coverage in NM (If Applicable)
UNM Family Medicine	

Other Practice Locations (If Applicable)					
Practice Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			

Education (Please attach a separate sheet, if necessary.)

Undergraduate Education							
College or University	University of Oregon						
City	Eugene	State/Country	OR	Zip Code:	97403		
Dates Attended	From: 9/96 To: 3/00	Degree	B.S.	Graduation Date	3/2000		
College or University	University of California Santa Barbara						
City	Santa Barbara	State/Country	CA	Zip Code:	93106		
Dates Attended	From: 9/95 To: 6/96	Degree	—	Graduation Date	—		
Professional / Medical Education							
College or University	Oregon Health and Sciences University						
City	Portland	State/Country	OR	Zip Code:	97239		
Dates Attended	From: 8/03 To: 6/07	Degree	M.D.	Graduation Date	6/2007		
College or University							
City		State/Country		Zip Code:			
Dates Attended	From: To:	Degree		Graduation Date			
Graduate Education							
College or University	Portland State University						
City	Portland	State/Country	OR	Zip Code:	97201		
Dates Attended	From: 9/2008 To: 6/2011	Degree	M.P.H.	Graduation Date	6/2011		
College or University							
City		State/Country		Zip Code:			
Dates Attended	From: To:	Degree		Graduation Date			

Internship/ Residency/ Fellowship					
Institution Name	Oregon Health and Sciences University				
City	Portland	State/Country	OR	Zip Code:	97239
Dates Attended	From: 7/07 To: 6/10	Field	Family Medicine		
Institution Name	Oregon Health and Sciences University				
City	Portland	State/County	OR	Zip Code	97237
Dates Attended	From: 7/10 To: 6/11	Field	Preventive Medicine		
Institution Name					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Field			
Institution Name					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Field			

Work History

Please list all previous practice experience for the last 15 years, **including military or government service**, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents**. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location	Portland, OR	From	7/07	To	6/10
Street	3181 SW Sam Jackson Park Road	Phone Number		503-494-7591	
City	Portland	State	OR	Zip Code	97239
Type of Practice	Family Medicine	Contact Person		Roger Garvin, MD	
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

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Hospital and Health Facility Affiliation History

(other than postgraduate training) ☒ **N/A**

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. **Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.**

(1) Current Primary Admitting Facility (Hospital Name)					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(2) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

(4) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(5) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(6) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(7) Facility Name					
Street					
City		State		ZIP Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(8) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title	Roger ~~Garvin~~ Garvin, MD				
Address	3181 SW Sam Jackson Park Road				
City	Portland	State	OR	Zip Code	97239
Telephone Number	503-494-7591	Facsimile			
(2) Name and Title	Jessica Flynn, MD				
Address	3181 SW Sam Jackson Park				
City	Portland	State	OR	Zip Code	97239
Telephone Number	503-494-8311 paging ~~operator~~	Facsimile			
(3) Name and Title	Clifford Coleman, MD				
Address	3181 SW Sam Jackson Park Rd				
City	Portland	State	OR	Zip Code	97239
Telephone Number	503-494-8311 paging operator	Facsimile			

Applicant Name Nicole Yonke **Date** 12/1/10

Licensure-Registration-Certification Information

ECFMG Number (if applicable)						
State Professional License/Certification Number				MD 151075		
State	OR	Issue Date	1/1/11	Expiration Date	12/31/11	Pending ☐

All Other State License Numbers (regardless of status - attach separate list if necessary.)

State	Number	Issue Year	Expiration Date
n/a			

***Federal Drug Enforcement Admin. (DEA) Registration**					N/A ☐
Number	[redacted]	Exp. Date	05-31-13		Pending ☐
***State Controlled Substance Registration** (CSR)					N/A ☒
Number		State	Exp. Date		Pending ☐
***Medicare Unique Physician Identification Number (UPIN)**					
Pending ☐					
***State Medicaid Provider Number**					
Pending ☐					
***National Provider Identification Number**					
Pending ☐	1053514497				

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Specialty Board Certifications ☐N/A

Are you Board Certified? ☒Yes ☐No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the:					
1. American Board of Family Medicine					
Date Certified	7/13/10	Date Last Recertified	n/a	Expiration Date	12/31/17
2.					
Date Certified		Date Last Recertified		Expiration Date	
3.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the:					
Until (expiration date)		If not accepted, have you made application?		Yes No	
Certified/Recertified by the Subspecialty Board of					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the Subspecialty Board of					

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☒Yes ☐No

Current Carrier	~~Oregon~~ OHSU Insurance Company			Current ☒	Pending ☐
Address	3181 SW Sam Jackson Park Road, Portland, OR 97239				
Dates Insured	From 7/07	To 6/11	Policy #	1-1000-00	
			Coverage Limits	$3,000,000	

Applicant Name Nicole Yonke **Date** 12/1/10

Licensing Exam: **Please check all that apply:**

☐ **State Board Exam (Prior to 1973)** Which state? _____ Date(s) passed? _____

☐ **FLEX** ☐ **LMCC** ☐ **National Board (NBME)** ☒ **USMLE**

Part/Step 1 Date Passed 6/16/05 (Month/Year) Part/Step 2 Date Passed 9/21/06 (Month/Year) Part/Step 3 Date Passed 6/18/08 (Month/Year)

Professional Practice Questions Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐	No ☒
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☒
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☒
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☒
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☒
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐	No ☒
7. Have you ever been named as a defendant in any criminal proceedings?	Yes ☐	No ☒
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐	No ☒
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☒
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes ☐	No ☒
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐	No ☒
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐	No ☒
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes ☐	No ☒
b. Are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☒
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☒
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☒

Applicant Name Nicole YonKe **Date** 12/1/10

15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, please provide the following information on the attached Malpractice History form for each case:** • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☐	No ☒
16. Have you ever been reported to the National Practitioner Data Bank?	Yes ☐	No ☒
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	Yes ☐	No ☒
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	Yes ☐	No ☒
19. Have you ever, for any reason:		
a) Resigned from a medical school or postgraduate training (PGT) program?	Yes ☐	No ☒
b) Withdrawn from a medical school or postgraduate training program?	Yes ☐	No ☒
c) Been suspended, dismissed, or expelled from a medical school or PGT program?	Yes ☐	No ☒
d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	Yes ☐	No ☒
e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	Yes ☐	No ☒

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220

APPLICANT'S OATH

I, Nicole Yonke, **hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.**

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

Nicole Yonke 12/1/10
Applicant Signature Date

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name Nicole Yonke **Date** 12/18/10

American Board of Family Medicine

Nicole Yonke, M.D.

having met all its requirements

is hereby certified to be a

Diplomate

of this Board for the period

2010-2017

Chair

President

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

NICOLE JOY YONKE MD
[redacted]

Primary Office Address:

OHSU
3181 SW SAM JACKSON PARK RD
PORTLAND OR 97239-3098

Phone: UNKNOWN

Birthdate: [redacted]1977
Birthplace: VAN NUYS, CA 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:

**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:

OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201

Degree Awarded: Yes

Degree Year: 2007

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: OR HLTH SCI UNIV HOSP
Specialty : FAMILY MEDICINE

State: OREGON
07/2007 - 06/2010
(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
OREGON	MD	04/05/2010	12/31/2010	ACTIVE	UNLIMITED	10/18/2010
OREGON	MD	07/01/2009	07/31/2010	INACTIVE	LIMITED	10/18/2010
OREGON	MD	07/01/2008	06/30/2009	INACTIVE	RESIDENT	07/16/2009
OREGON	MD	07/01/2007	06/30/2008	INACTIVE	RESIDENT	07/16/2009

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.**

Current and/or Historical NPI Information:

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1053514497	06/05/2007	NOT RPTD	NOT RPTD	NOT RPTD	05/03/2010

AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

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
XXXXXX915	22N 33N 4 5	05/31/2013	12/13/2010

Address: Ohsu, 3181 SW Sam Jackson Park Rd, Portland, OR 97239-3098

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.

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 and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY MEDICINE
Certificate Type: GENERAL

Duration	Effective	Expiration	Occurrence	Last Reported
TIME LIMITED	07/13/2010	12/31/2017	INITIAL	12/09/2010

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.

AMA Physician Profile

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.

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 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 60654
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.

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

December 21, 2010

Attn: Lynn Hart
New Mexico Medical Board
2055 S. Pacheco, Bldg.400
Santa Fe, NM 87505

Re: Board Action Query Dated: December 21, 2010
Your Reference Number:
FSMB Batch Number: BQ1849375

The following is a report of the search results from the Board Action Data Bank as of December 21, 2010 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of December 21, 2010

Item	Name	DOB	School	Yr/Grad	Request ID
2	[redacted]		28010	0784	23143961
			able		
6			10040	0810	23143989
			able		
1			10011	0508	23143956
			able		
9			47020	0592	23144014
8			23030	0700	23144007
4			04080	0500	23143978
3			32010	0505	23143968

5	[redacted]			0692	23143983
10				0506	23144021
7	yonke, nicole	11/28/1977	038010	0607	23144002

LICENSE HISTORY
State Board
OREGON

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

Nicole Joy Yonke, MD

Licensed Physician #MD2011-0120

Issue Date	Expiration Date
03/02/2011	07/01/2011
Signature of Holder	

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Nicole Joy Yonke, MD

License Number: MD2011-0120

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 03/02/2011 Date Expires: 07/01/2011*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

Oregon

Medical Board
1500 S.W. First Ave., Suite 620
Portland, OR
Voice (971) 673-2700
FAX (971) 673-2670
www.oregon.gov/OMB

December 15, 2010

New Mexico Medical Board
2055 S Pacheco St Bg 400
Santa Fe NM 87505

REPORT NAME:	**LICENSE VERIFICATION**
REPORT SUBJECT:	**Nicole Joy Yonke, MD**
LICENSE #:	**MD151075**

This Oregon Medical Board is responding to your inquiry regarding verification of licensure for the above-referenced Licensee. Enclosed is a License Verification Report for this Licensee.

There are no Board Orders on file for this Licensee.

If you have any questions regarding this License Verification Report, please contact the Board at (971) 673-2700, or toll free in Oregon at (877) 254-6263.

Sincerely,

Linda Sears

Linda Sears
Accounts Receivable Specialist

Enclosure

Oregon Medical Board
1500 SW First Avenue, Suite 620
Portland, Oregon 97201-5847
(971) 673-2700 • www.oregon.gov/omb

LICENSE VERIFICATION REPORT

Licensee:	**Yonke, Nicole Joy, MD**
Gender:	**Female**
Year of Birth:	**1977**

PRACTICE LOCATION

Business Phone:	
City, State:	**Portland, OR**
County:	**Multnomah**

LICENSE

Number:	**MD151075**	Type:	**MD License**
Current Status:	**Active - One Year**	Expedited Endorsement:	No
Basis:	**USMLE**		
Issued:	**04/05/2010**		
Expires:	**12/31/2010**		
Specialty:	**Family Medicine**		

OTHER LICENSES

Number	Effective Date	Expiration Date	License Type
LL17244	**07/01/2007**	**06/30/2008**	**MD Postgraduate License**
LL17579	**07/01/2008**	**06/30/2009**	**MD Postgraduate License**
LL18288	**07/01/2009**	**07/31/2010**	**MD Postgraduate License**

EDUCATION

School:	**OREGON HLTH AND SCI UNIV SCH OF MED**
Location:	**PORTLAND, OREGON, USA**
Graduation:	**06/08/2007**

BOARD ORDERS

Standing: **Unrestricted - There are no Board Orders on file for this Licensee**

Board Seal

Report Prepared By: Linda Sears

Linda Sears

Report Date: **12/15/2010**

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Nicole Joy Yonke**
SSN:	[redacted]
DOB:	
Packet ID:	**127954**
Recipient:	**New Mexico Medical Board**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Nicole Joy Yonke**	
Other Name Used:	**Nicole Joy Jonke**	
Gender:	**Female**	
Date of Birth:	[redacted]77	
Place of Birth:	**Van Nuys, CA USA**	
SSN:	[redacted]	
Current Address:	**3473 Southwest Barbur Boulevard # 11** **Portland, OR 97239**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**N/A**
	Fax:	**N/A**
	Home:	**503-544-8052**
	Other:	**N/A**
Physical Description:	Height:	**5' 05"**
	Weight:	**145 lbs**
	Eye Color:	**Blue**
	Hair Color:	**Brown**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**Portland Community College, Portland, OR 97280**
Dates of Attendance:	**09/1993 - 06/1994**
Degree Conferred/Issued:	**None**
Institution:	**Portland State University, Portland, OR 97207**
Dates of Attendance:	**09/1994 - 03/1995**
Degree Conferred/Issued:	**None**
Institution:	**University of California Santa Barbara, Santa Barbara, CA 93106**
Dates of Attendance:	**09/1995 - 06/1996**
Degree Conferred/Issued:	**None**
Institution:	**University of Oregon, Eugene, OR 97403-5257**
Dates of Attendance:	**09/1996 - 12/1996**
Degree Conferred/Issued:	**Bachelor of Science**
Institution:	**University of Pittsburgh, Pittsburgh, PA 15260**
Dates of Attendance:	**01/1997 - 05/1997**
Degree Conferred/Issued:	**None**

Institution:	**California State University Long Beach, Long Beach, CA 90840**
Dates of Attendance:	**01/2002 - 05/2002**
Degree Conferred/Issued:	**None**

Medical Education:

Medical School:	**Oregon Health and Science University School of Medicine** **Graduate Medical Education L109A** **31891 SW Sam Jackson Park Road** **Portland, OR 97239**
Dates of Attendance:	**08/25/2003 - 06/08/2007**
Date Degree Conferred/Issued:	**06/08/2007**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Graduate Medical Education:

Institution:	**Oregon Health Sciences University** **Department of Family Practice** **3181 SW Sam Jackson Park Road** **Portland, OR 97239**
Training Level:	**1-3**
Program Type:	**Residency**
Specialty/Subspecialty:	**Family Medicine**
Dates of Attendance:	**07/01/2007 - 06/30/2010**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Institution:	**Oregon Health & Science University** **Dept of Public Hlth and Preventative Med** **3181 SW Sam Jackson Park Road CB 669** **Portland, OR 97239**
Training Level:	**Not Reported by the Primary Source**
Program Type:	**Residency/Chief Residency**
Specialty/Subspecialty:	**Preventive Medicine**
Dates of Attendance:	**07/01/2010 - 06/30/2011**
Completion:	**To Be Completed On 06/30/2011**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Nicole Joy Yonke
DOB:	[redacted]
SSN:	
Packet ID:	127954
Request ID:	23116919

OMISSIONS

There are none identified.

DISCREPANCIES

There are none identified.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile:	**Post-Graduate Education**
Issue:	The applicant reports program type for 07/2007 to 06/2010 is Internship/Residency. Oregon Health Sciences University reports program type for 07/01/2007 to 06/30/2010 is Residency.
Follow-Up:	FCVS does not follow up on program type based on the definition of a resident per ACGME (A physician at any level of GME in a program accredited by the ACGME is considered a resident).

End of report for Nicole Joy Yonke

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

February 22, 2011

FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: February 22, 2011
Your Reference Number:
FSMB Batch Number: BQ1872401

The following is a final report of the search results from the Board Action Data Bank as of February 22, 2011 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of February 22, 2011

Item	Name	DOB	School	Yr/Grad	Request ID
7	Yonke, Nicole Joy	[redacted]/1977	038010	2007	23374980

LICENSE HISTORY
State Board
OREGON

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 2/22/2011

State Queried For:	New Mexico Medical Board
Physician Name:	Nicole Joy Yonke
Date of Birth:	[redacted]1977
Year of Graduation:	2007 (Doctor of Medicine)
Social Security Number:	
ABMSU ID:	948538

Certification:

Board:	Family Practice
Specialty:	Family Practice
Status:	ACTIVE
Initial Certification:	07/13/2010

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

Applicant's Signature (must be signed in the presence of a notary)

Yonke
Applicant's Printed Last Name

Nicole J.
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

12/14/10
Da[redacted]

11/28/77
Date of Birth

Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

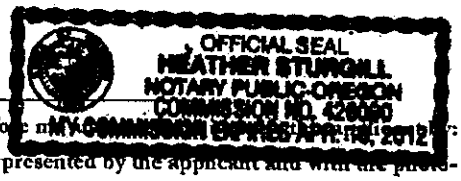
State of Oregon County of Multnomah

SUBSCRIBED AND SWORN TO before me this 14th day of December, 20 10

My commission expires: April 16, 2012

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature:



I certify that on the date set forth above the individual named above did appear personally before me and I identified him/her by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

127954

FORM 2

IN THE CIRCUIT COURT OF THE STATE OF OREGON
For Multnomah County

In the Matter of the Change of Name of:

Jonke, Nicole, Joy
Your Present Name - Last, First, Middle

to

Yonke, Nicole, Joy
Your New Name - Last, First, Middle

Case No. 1012-17407

NOTICE OF NAME CHANGE HEARING (ADULT)

Based upon the Petition filed in this case, this Court will consider the name change request of the Petitioner on the 3 **day of** February, 20 10, **at** 8:45 **a.m. in Room 211 of the of the Multnomah County Courthouse, located at: 1021 SW 4th Ave., Portland, Oregon.**

This written notice of the time, place and subject of the above-named hearing shall be posted in a public place located in Multnomah County, Oregon for fourteen (14) days prior to the hearing, beginning on 12/13/10 ***Today's date***, **and ending**

on February 3, 20 11.
Date of Hearing

This posting shall be filed as proof before the hearing.

Dated this 13 **day of** December, 20 10.

Nicole Yonke
Signature of Petitioner (Present Name)

Section III

Medical Education

F[redacted]RATION CREDENTIALS VERIFICATION SERVI[redacted]CVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

RECEIVED
JAN 19 2011
[redacted] Registrar

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Oregon Health and Science University School of Medicine

Complete Address: 3181 SW SAM JACKSON PARK RD

Street Address: _____

City: PORTLAND **State:** OR **ZIP Code (Postal Code):** 97239-3098

If name of institution was different when this individual attended, please note this name below:

_____

Premedical Education:

Years of education required for admission to your medical school: BS or BA

Credential/degree presented by the applicant for admission to your medical school: BS

Enrollment and Participation: Our records indicate that NICOLE J. YONKE
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 161 weeks of medical education on the following dates (mm/dd/yy):

From 08 / 25 / 03 (Month / Date / Year) **To** 06 / 08 / 07 (Month / Date / Year)

This individual (check one):

Was awarded the degree of DOCTOR OF MEDICINE on 06 / 08 / 07 (Month / Date / Year)

Was NOT awarded a degree because: _____
(please explain - attach additional pages if necessary)

Certification: By my signature, I, GERRI CHANTI (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available, this form must be notarized.

SEAL VERIFIED

Signature: Gerri Chanti GERRI CHANTI

Title: ADMIN COORD

Date of Signature: 1/21/11

Phone: (503) 494-7800 **Fax:** (503) 494-4629

Email: REGOHSU@OHSU.EDU

MLarrison

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during **any part** of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☐ NO ☑

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☑

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES ☐ NO ☑

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response YES ☐ NO ☑

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
   Response YES ☐ NO ☑

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

PROVIDED BY APPLICANT

Medical Education

School	038010 - Oregon Health and Science University School of Medicine
Address	3181 S.W. Sam Jackson Park Road
	Portland, OR 97239
	USA
Phone	503-494-7800
Dates	09/2003 - 06/2007 **Grad Date** 06/09/2007
Degree	MD - Doctor of Medicine
Program 6+ years:	N
Completed clinical clerkship in a country other than where my medical school was located:	N
Clinical Training	
Unusual Circumstances	
Leaves/Extensions	N
Probation	N
Disciplined	N
Negative Reports	N
Limitations	N

OHSU
Oregon Health & Science University

SCHOOL OF MEDICINE
OFFICE OF THE DEAN

Mail code: L102 • 3181 S.W. Sam Jackson Park Road • Portland, Oregon 97239-3098
TEL: 503 494-8220 • FAX: 503 494-3400

NICOLE J. YONKE

Medical Student Performance Evaluation

INTRODUCTION

Nicole J. Yonke has applied to your program for residency training from Oregon Health & Science University School of Medicine located in Portland, Oregon. This letter will help you to interpret his/her academic abilities and personal characteristics, as well as to better appreciate important aspects of the medical education program. While grade point averages and numerical class ranking are not calculated for our students, it is hoped that this letter, the academic transcript and other letters of recommendation will enable you to make a thorough assessment.

ACADEMIC HISTORY

Matriculation:	Monday, August 25, 2003
Expected Graduation:	Friday, June 8, 2007. The student will have participated in 161 weeks of required teaching.
Combined Degree:	None
Leaves of Absences:	None
Other Actions:	None

ACADEMIC PROGRESS

PRECLINICAL RECORD

The preclinical curriculum consists of multi-disciplinary units in the basic medical sciences beginning with a focus on normal structure and function and concluding with an emphasis on disease processes and their management. The Principles of Clinical Medicine course addresses a spectrum of health care issues important to physicians and society, provides patient examination skills development, and a continuity clinical preceptorship experience throughout the first and second years.

Grades for the preclinical courses are as follows: Honors in 4, Near Honors in 7, and Satisfactory in 4.

EVALUATION COMMENTS FROM PHYSICIAN PRECEPTORS IN YEARS 1 & 2 INCLUDE:

Nicole was interested in all the patients, was always on time and presented good succinct histories summarizing pertinent details. Nicole has certainly and dramatically progressed in the clinical arena. She has attained the necessary clinical skills and

interviewing techniques. She is curious, thoughtful and uses good clinical judgment. Her history taking is terrific and her presentations and write-ups are excellent. She demonstrated excellent interpersonal skills in her interactions with patients, ancillary staff and the other healthcare providers. The patients all enjoyed meeting her and interacting with her. Nicole is doing a great job - she's interested, asks great questions, very teachable and is clearly bright and directed; she was a pleasure to have in clinic.

CLINICAL CLERKSHIP COMMENTS ACCORDING TO ROTATION SCHEDULE AS RECEIVED FROM DEPARTMENT

Family Medicine **Near Honors** **Summer 2005**
Weekly small group case presentations and discussions: Dr. Bruin Rugge wrote regarding her medical test presentation, "Good and thorough review." Dr. John Saultz remarked regarding her family medicine presentation, "You chose two patients who were absolutely perfect for this exercise, but you didn't tell us much about your own observations or conclusions about them." Preceptorship: Nicole's preceptor Dr. Greg Saunders summed up her performance, "She has a solid fund of knowledge and application of this. She has a good sense of humor and is a pleasure to work with. Patients really seemed to like her and she worked well with the staff. Her apparent empathy will serve her well. It is hard to fully assess this given it is her first rotation of 3rd year- continued work on organizing medical problems and directed exams."

Obstetrics/Gynecology **Near Honors** **Summer 2005**
Nicole is bright and hard working. I hope that she chooses obgyn for her career. Nicole's history and physical exam skills and assessments are appropriate for her level of training. She developed these further and became more efficient during her rotation. She is an active team participant. One of the best students at responding quickly and precisely to any criticisms. She will go very far with this as she is never satisfied with "good enough". Her performance improved every day. Nicole did an excellent job. She took excellent histories, and presented them succinctly. Her exam skills were very good for her level of training. Her fund of knowledge clearly expanded in the course of the rotation. She will be an excellent physician.

Internal Medicine I **Near Honors** **Fall 2005**
Nicole had six evaluations from residents and faculty from which this summary is based. "From the start she was confident and competent in her dealings with her patients and the team. Her history taking and physical exam skills were thorough and well-organized...Nicole really does a great job thinking about what physical exam points she will need to focus on and how to utilize the physical exam to answer specific questions she has formulated prior to entering the room." She had "excellent flow of the history, data analysis and plan (with) good avoidance of irrelevant information. Her ability to present in a smooth, fluid fashion reflected a solid understanding of her patients. Nicole had a great feel for knowing what to include in oral presentations. She was always to the point in highlighting the key issues of the patient's presentations." She produced "very complete and well-written write-ups. She was able to identify the major problems to be addressed with her patients and give an organized discussion of the relevant

differentials and management plans." Progress notes were "well written and informative. (She) outlined daily plans well and concisely." They are "organized, legible, and timely... (and) did a great job of highlighting the team's plan for the day. "Nicole was felt to have a "solid knowledge base and quick to research areas of deficit." She "knew how to mesh her knowledge from year one and two, with clinical knowledge." "Nicole made great strides in her clinical problem solving. Integration of knowledge and actual clinical applications is difficult to do as a student, and she quickly mastered this task." She "demonstrated a good understanding of the problems of the patient reflecting appropriate identification of the problems and good reasoning in synthesizing the data. (She) appropriately sought the guidance of other team members/resources. "Nicole "worked very hard with her team and was always an enthusiastic team member. She made the effort to get to know her patients well and really take responsibility for their care...Nicole did a great job of helping out the team. She could be relied on to help gather data, outside records, etc. that really helped streamline patient care...She interacts well with nurses and ancillary staff. "In summary, Nicole demonstrated she had strong clinical skills and a sound knowledge base while having wonderful personal and professional qualities. She is very well suited for her plans as a primary care physician.

Psychiatry **Satisfactory** **Winter 2006**
It was a pleasure working with Nicole during her psychiatry rotation. She is a good-natured individual who is consistently punctual, hard-working, and professional. Her patient work-ups were always accurate detailed and thorough. Her clinical reasoning skills were sound. Her demeanor was pleasant and professional, and she interacted well with her patients and colleagues.

Primary Care **Near Honors** **Winter 2006**
Dr. Jackson felt that Nicole demonstrated a very good understanding of the common patient problems and medical procedures encountered in the clinic. She readily assumed responsibility for first-encounter evaluation of patients and demonstrated thorough history and physical examinations, case presentations, and patient management. Nicole handled all aspects of communication and referrals with a good level of understanding of community resources and was quick to recognize the limited resources of rural health care. Dr. Jackson felt that Nicole's overall performance was Near Honors. Dr. Jackson said, "I think Nicole will make a fine physician no matter what her final choice of specialty will be. "Nicole's clinical discussion question presentation was judged to be Near Honors. Her community project, which related to current standards of care for diabetes mellitus management, was judged to be Honors.

Surgery I **Near Honors** **Spring 2006**
Nicole did an excellent job on the Surgery 720 rotation. Her fund of basic knowledge was considered appropriate for her level of training. Her preceptor noted, "Nicole was enthusiastic, interested and did a substantial amount of outside reading to learn about her patients." The attendings noted, "Nicole was quiet but very knowledgeable and efficient. Good job. She is very caring and was concerned about her patients; she relates well to them as well as to the team. Nicole is very interested in learning and seeks new information avidly. She scrubbed in for an 8 hour case and stayed longer

than any resident. Nicole is enthusiastic and her fund of knowledge is good. Good patient presentations and thorough notes."

Child Health I **Honors** **Spring 2006**
Nicole received the grade of Honors for her performance on the Child Health One clerkship. Nicole hit the inpatient unit running and almost immediately was functioning at the level of an intern. She took a genuine interest in learning pediatric medicine and clearly utilized many opportunities to learn from her patients and fellow team members. In the newborn nursery, she was absolutely outstanding, catching on very quickly with an excellent fund of knowledge. Often, she knew more than the pediatric intern and she had very good, intuitive clinical skills. Never pushy or over-confident, she cared for her patients on multiple levels, formulating differential diagnoses and management plans at a level rarely seen in students during the MS3 year. She performed extremely well on the final exam, an interactive cased-based computerized evaluation tool. She received the grade of Honors for her required clerkship project, a presentation entitled, "Assessing Cerebral Palsy At Six Weeks of Life."

PROFESSIONALISM ASSESSMENT

Outlined below are the professionalism standards assessed during each of the required clerkships:

Honesty and Integrity Dependable for reporting accurate information; handles confidential information appropriately; and accepts responsibility for their assigned role in the care of patients and the clerkship.

Respect for Others and Teamwork: Avoids arrogance toward others; behaves in a respectful manner to people with differing beliefs and personalities; collegially works with nurses and other professionals; demonstrates respect for other learners; and appropriately attributes sources of information in written products.

Respect for Patients: Demonstrates compassion for patients and appropriately advocates for patients' needs.

After final assessment, Nicole Yonke has met the OHSU School of Medicine professionalism expectations.

UNIQUE CHARACTERISTICS

Nicole Yonke has been an active member of the university and her community. Her first year of medical school she became a leader in the Global Health Association, helping to organize global health events and awareness at OHSU. Nicole has also been very active in the family medicine interest group, attending state and national meetings. This year she is the Student Representative to the Board of Directors of the Oregon Association of Family Physicians, and is involved with their Legislative Committee. She is also serving as a leader of MedNet, a peer-advising group. Nicole's dedication to

serving those in need is evidenced by her volunteer work at Wallace Medical Concern, Desarrollo Integral de la Familia, Girls Inc, and other community health fairs. She also volunteered at Cascade AIDS Project, facilitating a group aimed at improving health literacy. In her spare time, Nicole enjoys traveling, hiking, camping, backpacking, and yoga.

SUMMARY

Students at Oregon Health & Science University School of Medicine are recommended as candidates for postdoctoral training in four categories based upon an evaluation of their overall academic performance. This final assessment is based on a relative weighting of 33% for performance in the preclinical curriculum and 66% performance in the core clinical clerkships. The categories include: Outstanding (30), Excellent (31), Very Good (35), and Good (26). Following careful consideration by the Residency Advisory committee, Nicole Yonke has been recommended as a Very Good candidate.

Sincerely,

Molly Osborne, M.D., Ph.D.
Associate Dean for Student Affairs

Edward J. Keenan, Ph.D.
Associate Dean for Medical Education

P.S. If you have specific questions regarding this applicant, I can be reached at 503-494-5260 or osbornem@ohsu.edu

Oregon Health & Science University
School of Medicine
Class of 2007

First Year Curriculum
Anatomy, Imaging and Embryology
Cell Structure and Function
Systems Process and Homeostasis
Biological Basis of Disease
Principles of Clinical Medicine I, II, III
Clinical Preceptorship

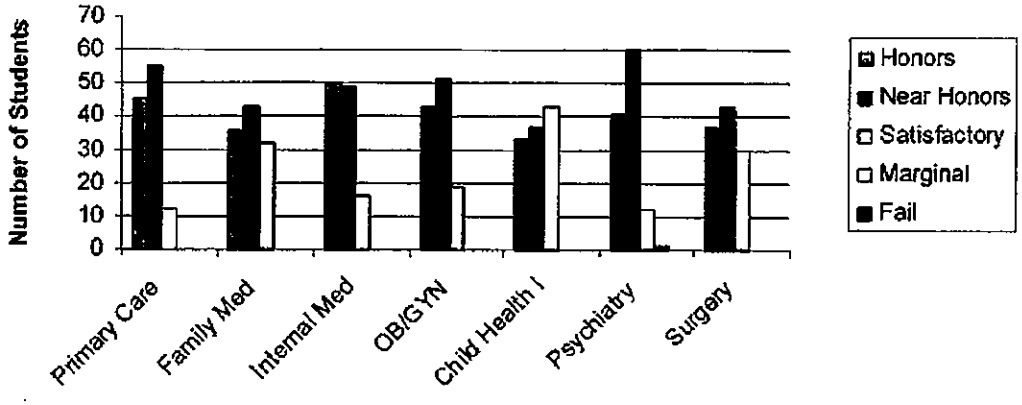
Second Year Curriculum
Neurosciences and Behavior
Circulation
Blood
Metabolism
Human Development and Life Cycle
Principles of Clinical Medicine IV, V, VI
Clinical Preceptorship

Third Year Curriculum

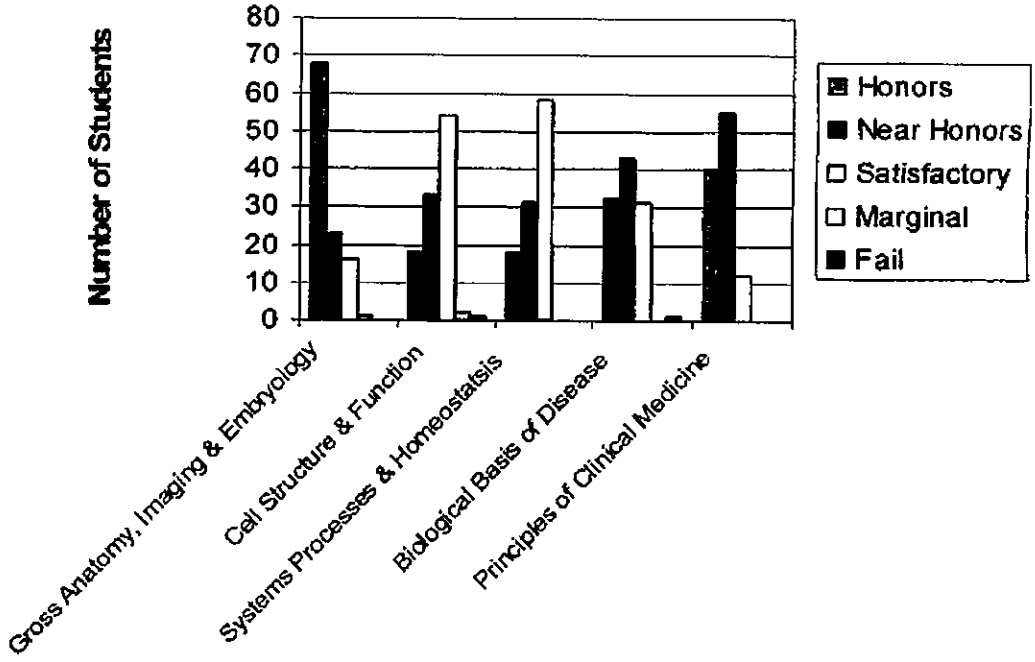
Internal Medicine	10 weeks
Surgery	5
Child Health I	5
Obstetrics and Gynecology	5
Psychiatry	5
Family Medicine	5
Primary Care (Rural)	5

Further Information
The Class of 2007 will have122 graduates.
OHSU requires all students to complete two 4th year Subinternships or ICU rotations in Internal Medicine, Family Medicine, Pediatrics, Obstetrics and Gynecology, Psychiatry or Surgery.
OHSU has an active Alpha Omega Alpha Chapter.
OHSU requires that students sit for USMLE Step 1, Step 2CS and Step 2CK, but not pass to graduate.
The narrative comments in the MSPE are reported exactly as written.
OHSU is completely in compliance with the AAMC "Guidelines for Medical Schools Regarding Academic Transcripts."
Students are permitted to review the MSPE prior to its transmittal.

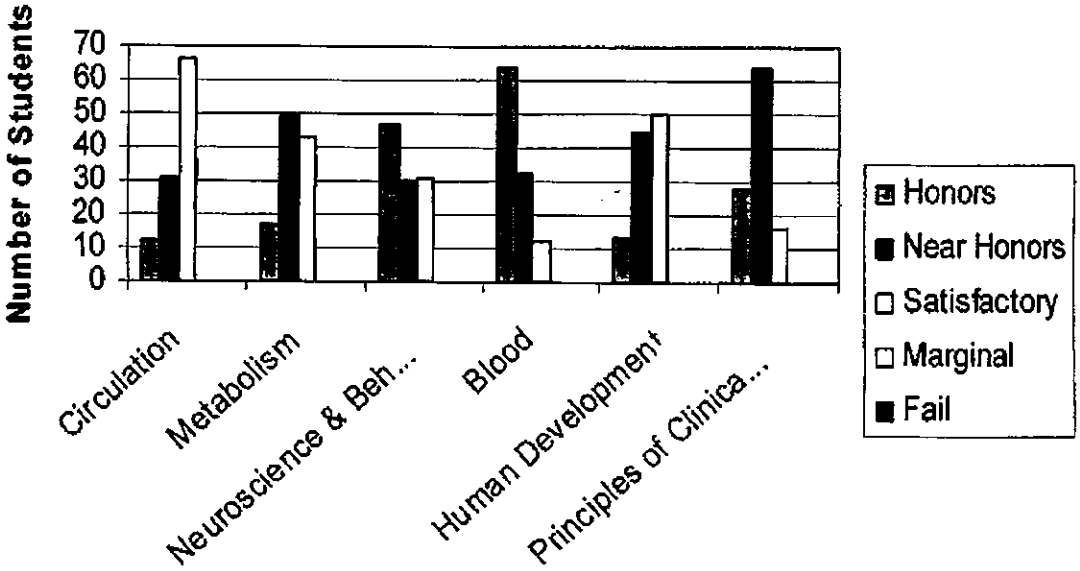
Core Clerkship Grade Distribution 2005-2006



1st Year Grade Distribution 2003-2004



2nd Year Grade Distribution 2004-2005



OREGON HEALTH & SCIENCE UNIVERSITY

SSN: [redacted] Student No: J00026683 Date Issued: 21-JAN-2011

Record of: NICOLE JOY YONKE Page: 1

Course Level: Medical
Matriculated: Fall 2003

Degree Awarded : Doctor of Medicine 08-JUN-2007
Major : Medicine

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	WKS
INSTITUTION CREDIT:						
Academic Year 2003-2004						
FAMP	709E	Summer Observership	0.00	P	0.00	2
GMED	705F	History of Medicine I	0.50	P	0.00	17
MSCI	611	Gross Anat/Imag/Emb	12.00	H	36.00	11
MSCI	612	Cell Structure & Function	8.00	S	8.00	11
MSCI	711	Principles of Clinical Med I	4.00	H	12.00	17
JCON	705G	The Healer's Art	1.00	P	0.00	12
MSCI	613	System Processes & Homeostasys	9.00	S	9.00	11
MSCI	712	Principles of Clinical Med II	4.00	H	12.00	12
PHPM	705F	Medical Spanish	1.00	P	0.00	12
JCON	705A	Health Problem/Devel Countries	2.00	P	0.00	12
MSCI	614	Biological Basis of Disease	9.00	NH	18.00	10
MSCI	713	Principles of Clinical Med III	4.00	H	12.00	12
PHPM	705G	Medical Spanish - Intermediate	1.00	P	0.00	7
		Total Earned Credits 55.50				
Academic Year 2004-2005						
MSCI	622	Circulation	8.00	S	8.00	10
MSCI	624	Metabolism	5.00	S	5.00	6
MSCI	714	Principles of Clinical Med IV	4.00	NH	8.00	16
MSCI	621	Neuroscience & Behavior	8.00	NH	16.00	9
MSCI	623	Blood	4.00	NH	8.00	5
MSCI	715	Principles of Clinical Med V	4.00	NH	8.00	12
MSCI	626	Human Development	6.00	NH	12.00	7
MSCI	716	Principles of Clinical Med VI	4.00	NH	8.00	8
		Total Earned Credits 43.00				
Academic Year 2005-2006						
FAMP	720	Family Medicine	9.00	NH	18.00	5
JCON	717A	Transition to Clerkship	3.00	P	0.00	1
OBGY	720	Obstetrics/Gynecology	9.00	NH	18.00	5
IMED	720	Internal Medicine I	18.00	NH	36.00	10
JCON	722	Primary Care	9.00	NH	18.00	5
PSYC	720	Psychiatry	9.00	S	9.00	5

********** CONTINUED ON NEXT COLUMN **********

OREGON HEALTH & SCIENCE UNIVERSITY

SUBJ	NO	COURSE TITLE	CRED	GRD	PTS	WKS
Institution Information continued:						
GMED	709G	Community Volunteer Med Clinic	0.00	AU	0.00	53
JCON	719	Continuity Curriculum/OSCE	2.00	P	0.00	2
JCON	720	Child Health I	9.00	H	27.00	5
SURG	720	Surgery I	9.00	NH	18.00	5
		Total Earned Credits 77.00				
Academic Year 2006-2007						
FAMP	709A	Family Practice	6.00	H	18.00	4
OTOL	709C	Ambulatory Care in Otolaryn	3.00	NH	6.00	2
PULM	709G	Pulmonary ICU - Good Sam	6.00	H	18.00	4
RADD	709A	Radiographic Diagnosis	6.00	H	18.00	4
ANST	709A	Anesthesiology	6.00	H	18.00	4
JCON	705V	MedNet I	1.00	P	0.00	1
NEUR	721	Neurology	6.00	NH	12.00	4
DERM	709A	Clinical Dermatology	6.00	H	18.00	4
JCON	705V	MedNet II	1.00	P	0.00	1
JCON	721	Child Health II	6.00	NH	12.00	4
GMED	709C	Community Volunteer Med Clinic	0.00	AU	0.00	13
JCON	709Z	International Medicine Extern	12.00	H	36.00	11
JCON	718	Transition to Residency	3.00	P	0.00	1
		Total Earned Credits 62.00				

********** TRANSCRIPT TOTALS **********

Total Earned Credits 237.50

********** END OF TRANSCRIPT **********

SEAL VERIFIED

OREGON HEALTH & SCIENCE UNIVERSITY

An official signature is white with a green background.

Charla Fennell
Director of Financial Aid & Registrar

OREGON HEALTH & SCIENCE UNIVERSITY

Office of the Registrar • (503) 494-7800 • www.ohsu.edu
3181 SW Sam Jackson Park Road, Portland, Oregon 97239

Former Names

1887: the University of Oregon established a medical school in Portland, Oregon. *1926*: the University of Oregon established a program in nursing. *1945*: the University of Oregon established a dental school by incorporating the North Pacific College of Oregon (formerly known as the North Pacific Dental College). *1974*: the Oregon Legislature established the University of Oregon Health Sciences Center as a free-standing institution within the Oregon State System of Higher Education. *1981*: the health sciences center was renamed Oregon Health Sciences University. *2001*: the Oregon Health Sciences University merged with the Oregon Graduate Institute of Science and Technology (formerly known as the Oregon Graduate Center prior to 1989) and was renamed Oregon Health & Science University.

Accreditation

Oregon Health & Science University is accredited by the Northwest Commission on Colleges and [illegible]versities. In addition, all appropriate health care programs are accredited by specialized [illegible]editing associations.

Calendar

Oregon Health & Science University operates on the term or quarter system.

Course Numbering System

200-299	Lower division level
300-499	Upper division level
500-599	Graduate courses offered primarily in support of master's level programs
600-699	Graduate courses offered primarily in support of doctoral level programs
700-799	Professional courses which may be applied to a professional degree

OGI School of Science & Engineering (Prior to September 2003)

400-499	Courses not eligible for graduate credit
500-599	Graduate courses
600	Pre-qualifying Ph.D. Research
610	Non-thesis Master's Research
620/650-621/651	Internship
700	Thesis Master's Research
800	Post-qualifying Ph.D. Research

School of Dentistry (Prior to June 2006)

[illegible] courses:

610-619	Professional courses offered primarily in support of first year curriculum
620-629	Professional courses offered primarily in support of second year curriculum
630/730-639/739	Professional courses offered primarily in support of third year curriculum
640/740-648/749	Professional courses offered primarily in support of fourth year curriculum

Graduate courses:

500-599	Graduate courses offered primarily in support of master's level programs
600-699	Graduate courses offered primarily in support of the Orthodontics program
700-799	Graduate courses offered primarily in support of master's level programs

Repeated Courses

A course followed by an E indicates the course has been repeated and has been excluded from the GPA calculation, the total earned credits and the degree requirements.

Grading System

School of Medicine - MD Program - *Prior to September 16, 1961*: I=91-100%, II=86-90%, III=81-85%, IV=76-80%, V=75% (barely passing). *Beginning September 18, 1961*: A=Exceptional, B=Superior, C=Average, D=Inferior, E=Conditional, F=Failure. *Beginning September 12, 1977*: H=Honors, Acc=Acceptable, M=Marginal, F=Failure, P=Pass, NP=No Pass, AU=Audit, I=Incomplete, W=Withdrew. Courses listing two grades, i.e. Acc/H are for knowledge/skills. *Beginning June 12, 1988*: H=Honors, NH=Near Honors, S=Satisfactory, M=Marginal, F=Failure, X=No Grade Received/No Basis for Grade, P=Pass, NP=No Pass, AU or AUD=Audit, I=Incomplete, W=Withdrew. The mark "M" necessitates remedial work with a mark of at least "S" or better on the academic record. The mark of "F" would require repeating the course. Beginning January 2006: I/(Grade)=Incomplete grade changed to final grade.

School of Medicine - Graduate and Allied Health Programs - *Prior to September 16, 1961*: I=91-100%, II=86-90%, III=81-85%, IV=76-80%, V=75% (barely passing). *Beginning September 18, 1961*: A=Exceptional, B=Superior, C=Average, D=Inferior, E=Conditional, F=Failure. *Beginning September 1989*: 4.0=Exceptional, 3.0=Superior, 2.0=Average, 1.0=Inferior, 0.0=Failure, P=Pass, NP=No Pass, AUD=Audit, I=Incomplete, X=No Grade Received/No Basis for Grade, W=Withdrew. For Allied Health beginning January 2006: I/(Grade)=Incomplete grade changed to final grade. *Beginning September 2003 (for Graduate Programs only)*: A=Exceptional, B=Superior, C=Average, D=Inferior (+ or - may be used with letter grades), F=Failure, P=Pass, NP=No Pass, AU or AUD=Audit, I=Incomplete, X=No Grade Received/No Basis for Grade, W=Withdrew, WS=Withdrew Satisfactory, WU=Withdrew Unsatisfactory. Beginning January 2006: I/(Grade)=Incomplete grade changed to final grade.

School of Nursing - *Prior to June 21, 1971*: A=Exceptional, B=Superior, C=Average, D=Inferior, F=Failure. *From June 21, 1971 to August 13, 1982*: A=Exceptional, B=Superior, C=Average, P=Satisfactory or better. N=Unsatisfactory.
Beginning September 27, 1982: 4.0=Exceptional, 3.0=Superior, 2.0=Average, 0.0=Failure, P=Pass, NP=No Pass, AUD=Audit, I=Incomplete, W=Withdrew, WS=Withdrew Satisfactory, WU=Withdrew Unsatisfactory, X=No Grade Received/No Basis for Grade, IP=In Progress. Beginning January 2006: I/(Grade)=Incomplete grade changed to final grade. *OHSU students on the Southern Oregon University (SOU) campus (formerly Southern Oregon State College (SOSC)): valid grades include A, B, C, D, F (with or without plus/minus), from September, 1993 through June, 1994 only.*

OGI School of Science & Engineering - *Beginning Fall 1998*: A=High Pass, B=Pass, C=Low Pass, (+ or - may be used with letter grades). F=Fail, P=Pass, NP=No Pass, W=Withdrawn, I=Incomplete, PI=Permanent Incomplete, AU=Audit, NG=No Grade Submitted. *2008*: OGI School of Science & Engineering merged in to the School of Medicine. *Beginning Fall 2008*: Refer to School of Medicine – Graduate and Allied Health Programs.

School of Dentistry - *Beginning Fall 1979*: Grades of 4.0, 3.5, 3.0, 2.5, 2.0, 1.5, 1.0, 0.0 also designate quality points per credit hour. Other grades are F=Fail, P=Pass, NP=No pass, EX=Exempt, AUD=Audit, I=Incomplete, W=Withdrew, WS=Withdrew Satisfactory, WU=Withdrew Unsatisfactory, *=no grade (for a continuing term course). Beginning Summer 2007: I/(Grade) = Incomplete grade changed to final grade.

OREGON HEALTH & SCIENCE UNIVERSITY

To all whom this writing may come, Greetings,

Be it known that

Nicole Joy Yonke

having successfully completed the prescribed course of study and having complied with all other requirements established by the University, is granted the Degree of

Doctor of Medicine

by authority of the State of Oregon and is entitled to all the rights and privileges appertaining to that Degree. In Testimony Whereof the Oregon Health & Science University Board of Directors upon recommendation of the Faculty has granted this Diploma this 8th day of June, A.D., 2007.

Jr E Robertson

Mark A Liebenow Jr MD

OHSU

CERTIFIED TO BE A TRUE COPY

Director Financial Aid/Registrar

SEAL VERIFIED

Section IV

Graduate Medical Education Training

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O.Box 619850, Dallas, TX 75261-9850

Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: Oregon Health Sciences University
Attention: **Program Director**

Address: FAMILY PRACTICE
Portland, OR 97239

Verification For: Name: Yonke, Nicole Joy
DOB [redacted]/1977

Individual's Name on Record (if different from above):,

Packet ID:127954 Request ID:23116919 IFM CODE:13902

PGY: 1-3
Program: Residency
Specialty/Subspecialty: Family Medicine
From: 7/1/2007 **To:** 6/30/2010
Complete?: Y
Accreditation: ACGME

Unusual Circumstances:

1. Did this individual ever take a leave of absence or break from his/her training?	N
2. Was this individual ever placed on probation?	N
3. Was this individual ever disciplined or placed under investigation?	N
4. Were any negative reports for behavioral reasons ever filed by instructors?	N
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reasons?	N

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Heather Sturgill
Title: Residency Coordinato
Email: fmres@ohsu.edu

Signature: *Heather Sturgill*
Date of Signature: 1/24/2011

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place / 400 Fuller Wiser Road Suite 300 / Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5098

Verification of Graduate Medical Education

Institution: Oregon Health & Science University

Address: Dept of Public Health & Preventive Medicine
Portland, OR 97239

Attention: **Program Director**

Affiliated University: ____

Verification For:

Name: Yonke, Nicole Joy

DOB [redacted]/1977

Individual's Name on Record (if different from above): ____

Program Participation:

Important:

Report incomplete Training Level's (years) separate from those that were successfully completed

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: ____ (e.g., 1, 2, 3, etc.)
☐ Internship
☒ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: PREVENTIVE MEDICINE
From: 07/01/2010 To: 06/30/2011
Successfully Completed?: ☐ Yes ☐ No ☒ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: ____ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ____
From: / / To: / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: ____ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ____
From: / / To: / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

____

____

ELECTRONICALLY SEAL VERIFIED

Certification:

Affix your institution's seal in this space. If no seal is available, you may leave this form unsealed

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature of the program director (M.D./D.O. ONLY – PLEASE REPORT WHICH).

Name: John Stull, MD, MPH
Signature: [signature]
Title of Signatory (e.g., Program Director): Program Director
Date of Signature: 02/08/2011
Tel: (503) 494-6958 Fax: (503) 494-4981 E-Mail: stullj@ohsu.edu

Miranda Larrison

To: Natalie Chin
Subject: RE: FCVS PID 127954 Dr. Nicole Joy Yonke Verification Request

---

From: Natalie Chin [mailto:chinn@ohsu.edu]
Sent: Thursday, February 10, 2011 3:12 PM
To: Miranda Larrison
Subject: RE: FCVS PID 127954 Dr. Nicole Joy Yonke Verification Request

Hi Miranda,

No worries! Thanks for checking ☺ Dr. Yonke is a chief resident. Thank you,

--
Natalie Chin
Residency Coordinator & Education Assistant
Department of Public Health & Preventive Medicine
Oregon Health & Science University
3181 SW Sam Jackson Park Road
Mail Code CB 669
Portland, Oregon 97239
(w) 503.494.1158 | (f) 503.494.4981
http://www.ohsu.edu/public-health

Graduate Medical Education

Hospital Oregon Health and Science University

Affiliated School

3181 S.W. Sam Jackson Park Rd.

Portland, NM 97239-3098

Year(s)	3	**Program Type**	Internship/Residency
Complete?	Yes	**Specialty/Subspecialty**	Family Medicine
Dates	07/2007 - 06/2010		

Year(s)	4	**Program Type**	Residency/Chief Residency
Complete?	In progress	**Specialty/Subspecialty**	Preventive Medicine
Dates	07/2010 - 06/2011		

Unusual Circumstances

Leaves/Extensions	N
Probation	N
Disciplined	N
Negative Reports	N
Limits	N

OREGON HEALTH & SCIENCE UNIVERSITY

OHSU

To all to whom this writing may come, Greeting:

Be it known that

Nicole J. Yonke, M.D.

having acceptably fulfilled the duties of

Intern in Family Medicine

in the University Hospital and Clinics and affiliated Hospitals for a period of one year beginning July 1, 2007 and ending June 30, 2008 is hereby granted this Certificate in acknowledgment of services loyally performed with all rights and privileges due thereunto appertaining

Dated at Portland, Oregon, June 30, 2008.

Joe E. Robertson, Jr.
President

Peter Rapp
Vice President and Executive Director
OHSU Hospitals and Clinics

Mark A. Richardson
Dean, School of Medicine

Associate Dean, Graduate Medical Education

Chair of Department, School of Medicine

Program Director

OREGON HEALTH & SCIENCE UNIVERSITY

To all to whom this writing may come, Greeting:

Be it known that

Nicole J. Yonke, M.D.

having acceptably fulfilled the duties of

Resident in Family Medicine

in the University Hospital and Clinics and affiliated Hospitals for a period of two years beginning July 1, 2008 and ending June 30, 2010 is hereby granted this Certificate in acknowledgment of services loyally performed with all rights and privileges due thereunto appertaining

Dated at Portland, Oregon, June 30, 2010

Joe E Robertson, Jr
President

Peter Rapp
Vice President and Executive Director
OHSU Hospitals and Clinics

Mark Richardson
Interim Dean, School of Medicine

Associate Dean, Graduate Medical Education

Chair of Department, School of Medicine

Program Director

Section V

Examination History/Score Transcripts

USMLE
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: 01/19/2011

Recipient:
Federation Credentials Verification Service
ATTN: FCVS
Euless, TX 76039

Packet ID: 127954

Examinee: Yonke, Nicole Joy
Alt Name(s):

Examinee ID#: 5-156-618-0
Date of Birth: [redacted]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

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
06/16/2005	Pass	214	182	87	75	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
09/21/2006	Pass	260	182	99	75	

Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
02/12/2007	Pass					

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
OREGON 06/18/2008	Pass	242	187	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.

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

Yonke, Nicole Joy **Medical Doctor** **MD2011-0120**

11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	04/07/2011
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	04/07/2011
12. b. Are any currently held licenses pending investigation or being challenged?	N	04/07/2011
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	04/07/2011
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	04/07/2011
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	04/07/2011
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	04/07/2011
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	04/07/2011
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	N	04/07/2011
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	N	04/07/2011
1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	04/07/2011
2. Since your last renewal have you been denied professional liability insurance coverage?	N	04/07/2011
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	04/07/2011
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	04/07/2011
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	04/07/2011
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	04/07/2011
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	04/07/2011
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	04/07/2011
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	04/07/2011
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	04/07/2011
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	04/07/2011
20. Are you ABMS (American Board of Medical Specialties) Board Certified?	Y	04/07/2011
21. If yes do you hold Lifetime Certification?	N	04/07/2011
22 . If yes do you hold Time Limited Certification?	Y	04/07/2011

Yonke, Nicole Joy **Medical Doctor** **MD2011-0120**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	06/05/2014
2. Since your last renewal have you been denied professional liability insurance coverage?	N	06/05/2014
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	06/05/2014
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	06/05/2014
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	06/05/2014
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	06/05/2014
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	06/05/2014
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	06/05/2014
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	06/05/2014
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	06/05/2014
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	06/05/2014
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	06/05/2014
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	06/05/2014
12. b. Are any currently held licenses pending investigation or being challenged?	N	06/05/2014
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	06/05/2014
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	06/05/2014
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	06/05/2014
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	06/05/2014
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	N	06/05/2014
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	N	06/05/2014
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	06/05/2014
20. Are you ABMS (American Board of Medical Specialties) Board Certified?	Y	06/05/2014
21. If yes do you hold Lifetime Certification?	N	06/05/2014
22 . If yes do you hold Time Limited Certification?	Y	06/05/2014

Yonke, Nicole Joy **Medical Doctor** **MD2011-0120**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	05/04/2017
2. Since your last renewal have you been denied professional liability insurance coverage?	N	05/04/2017
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	05/04/2017
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	05/04/2017
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	05/04/2017
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	05/04/2017
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	05/04/2017
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	05/04/2017
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	05/04/2017
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional	N	05/04/2017
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	05/04/2017
10. c. Since you last renewal, have you been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	N	05/04/2017
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	05/04/2017
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	05/04/2017
12. b. Are any currently held licenses pending investigation or being challenged?	N	05/04/2017
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	05/04/2017
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	N	05/04/2017
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	05/04/2017
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	05/04/2017
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	N	05/04/2017
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	N	05/04/2017
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC	Y	05/04/2017
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	Y	05/04/2017
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	05/04/2017
21. Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?	N	05/04/2017