

MEDICINE AND SURGERY

CERT. NUMBER \_\_\_\_\_ NAME WEYAND, JAMES ELBERT MASON  
 MEDICAL 10775 DATE 06-16-69 ACCT. NO. 8635  
 BASIC SCIENCE \_\_\_\_\_ DATE \_\_\_\_\_ FEE 50.00 DATE 4/18/1969

NATIONAL BOARD

MEDICAL EXAMINATION RECIPROCITY FROM  
 BASIC SCIENCE EXAMINATION RECIPROCITY FROM

EDUCATION	YR. GRAD.	DEGREE	SCHOOL
COLLEGE			
MEDICAL SCHOOL	1966	M.D.	Western Reserve
INTERNSHIP	YEARS	DATE COMP.	HOSPITAL
	1	1967	Virginia Mason Hosp.

EXAMINATIONS

BASIC SCIENCE	DATE	NO.	DATE	NO.	DATE	NO.
SUBJECT	GRD.		GRD.		GRD.	
ANATOMY						
BACTERIOLOGY						
CHEMISTRY						
HYGIENE						
PATHOLOGY						
PHYSIOLOGY						
AVERAGE						

MEDICINE	DATE	NO.	DATE	NO.
PHARMACOLOGY				
MEDICINE				
SURGERY				
OB/GYN				
PEDIATRICS				
AVERAGE				

BOARD ACTION

110-29-67

502

DIVISION OF PROFESSIONAL LICENSING  
STATE OF WASHINGTON

APPLICATION FOR  
MEDICAL LICENSE

DO NOT WRITE IN THIS BOX

		252	09	8635	4	17	69	13	17	7
Fund	Prog.	Source	Sub.	Account	MO	DA	YR	Code	County	ASSN

APPLICANT, PLEASE COMPLETE THE FOLLOWING (Please print clearly)

Sta 1

NAME WEYAND JAMES Gilbert Mason M MO DA YR  
LAST FIRST MIDDLE SEX BIRTHDATE

ADDRESS 4b 

1. GENERAL INFORMATION

Birthplace \_\_\_\_\_ Citizenship USA  
 Present Position Assistant Resident; OB-GYN University Hosp, Seattle

2. EDUCATION

State in chronological order the name and location of each high or preparatory school, college, university, or technical school attended, the time spent at each, and if graduate, the year of graduation.

Name and Location of Institution	Month - Day - Year From - To	Month - Day - Year Graduated	Degree Received
① Western Reserve Academy, Hudson, Ohio	9/1/54	6/1/58	
② Haverford College, Haverford, Penna	9/1/58	6/1/62	BA
③ Western Reserve University School of Medicine	9/1/62	6/1/66	MD

INTERNSHIP

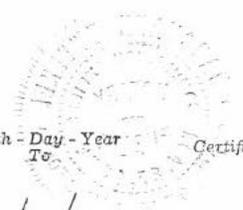
Name and Location of Hospital	Month - Day - Year From	Month - Day - Year To	Certificate
Virginia Mason Hosp, Seattle, Wash	6/24/66	6/24/67	yes

RESIDENCIES

Name and Location of Hospital	Month - Day - Year From	Month - Day - Year To	Certificate
University Hospitals Seattle, Wash.	7/1/67	7/1/71	now - still in residency

3. PREVIOUS REGISTRATION

Do you hold license in state of official residence? no (Name State) State license in Ohio - but official residence now Washington.  
 Permanent? \_\_\_\_\_, Temporary? \_\_\_\_\_, Number and date of certificate \_\_\_\_\_  
 Written or oral examination taken? yes (in Ohio) If not, how? \_\_\_\_\_  
 Is certificate now in force? \_\_\_\_\_ If not, why? \_\_\_\_\_  
 Has certificate ever been revoked? no If so, why? \_\_\_\_\_  
 Other states in which registered? Ohio



60-81144-1

## General Instructions

1. Each application must contain all the information required by law. In case of any doubt as to requirements, examine the law or write the Division of Professional Licensing, P. O. 649, Olympia, Washington 98501, for full information. Remember that a failure to answer properly all the questions asked in this form might result in the rejection of your application.
2. The application must be carefully filled out and sworn to before a Notary Public.
3. The letter of recommendation on page three of this form must be carefully made out and filed with the application. The letter must be signed by a reputable member of the profession.
4. An unmounted photograph of yourself taken within one year must accompany your application.
5. The application must be filed at least 60 days before the date of the examination, or 30 days prior to board meeting at which it is to be reviewed.

## Special Requirements

If any of the following questions are answered "Yes", full details must be furnished on separate sheet and attached.

- |  | Yes                      | No                                  |
|--|--------------------------|-------------------------------------|
| 1. Do you hold a license in any of the other healing arts?.....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have you ever been called before any state board for interrogation concerning any violation of the Medical Practice Act or unethical conduct? ..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you ever been convicted of a felony or misdemeanor other than traffic violations? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you ever been addicted to or treated for addiction to narcotic drugs? .....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you ever made an offer to compromise in connection with the Harrison Narcotic Law, or any narcotic law?.....                                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you ever received psychiatric treatment or received treatment for a mental illness?.....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism?.....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

### DESCRIPTION OF APPLICANT

Complexion <i>Medium</i>	Color of Hair <i>Brown</i>
Color of Eyes <i>Brown</i>	Height <i>5' 11"</i>
Weight <i>165#</i>	Distinguishing Marks <i>none</i>



*James G. M. Weyand, Jr. M.D.*

- MEDICINE AND SURGERY—
- (a) Copy of diploma issued by a medical school accredited and approved by the Board of Medical Examiners at time diploma was issued.
  - (b) Certificate showing not less than one year as intern in a thoroughly equipped hospital, having at least twenty-five beds for each intern, devoted to the treatment of medical, surgical, gynecological and special diseases.
  - (c) Evidence of some experience and practical working knowledge of obstetrics.
  - (d) Evidence of experience in and practical working knowledge of pathology.

### 4. AFFIDAVIT

I, JAMES GILBERT MASON WEYAND, JR., being first duly sworn, depose and say that I am the person above described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of Washington, particularly those acts set forth in Chapter 18.71 RCW.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files or records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application.

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

Subscribed and sworn to before me this 11 day of April, 1969.

*James G. M. Weyand, Jr.*  
(Usual business signature)

*Marcyann Snelker*  
Notary Public for KING COUNTY STATE OF WASHINGTON

My commission expires: NOVEMBER 25, 1972

### Schedule of Fees

	Examination	Re-Examination	Reciprocity (State)	National Board (Waiver)
Basic Science .....	10.00	10.00	25.00	
Medical .....	25.00	25.00	25.00	50.00*

\* Complete fee, includes both basic science and medical.

**FEE MUST ACCOMPANY APPLICATION**

No member of the profession is expected to sign this recommendation who does not know the applicant personally, and who is not willing to supply additional information concerning his or her character, standing and education, upon request from the Division of Professional Licensing.

LETTER OF RECOMMENDATION

City Seattle  
31 Jan, 1968

To the DIVISION OF PROFESSIONAL LICENSING, STATE OF WASHINGTON:

This certifies that I have known JAMES G M Weyand, Jr for \_\_\_\_\_ years; that I, personally, (Applicant's name in full) knew him while he resided at Seattle in the State of Washington during the years of 1966 to 1968, during which period he was engaged in active practice of Internship in as a student of Medicine; that he is of good moral and professional character; that he is free from habits liable to interfere with his professional services; that his standing was good in that community and is good in the community in which he now lives; that he is worthy of receiving a license to practice Medicine in the State of Washington.

Name George Hugh Lawrence MD  
Address 1117 Terry Ave Seattle Wash  
Licensed under the laws of Washington (Name of state)  
To practice Medicine + Surgery

Subscribed and sworn to before me this 31 day of January, 1968  
[Seal] Peris L. Lutz  
Notary Public for the State of Washington  
Residing at Seattle

CERTIFICATE OF MORAL CHARACTER  
To be signed by two reputable citizens

This certifies that I am acquainted with JAMES G M Weyand, Jr; that I believe him to be of good moral character and I hereby recommend him as entirely worthy of the license for which he has applied.

Name Sean R. Gardner MD  
Address Univ Hospital, Seattle, Wash.  
Name Wayne L. Johnson MD  
Address University Hospital, Seattle, Wa.

## RECIPROCITY

Applicants for license by reciprocity in addition to answering the questions on pages 1 and 2, and furnishing the letter and certificate on page 3 of this form, must give satisfactory answers to the following:

1. What state issued your original license?.....
2. Was such license granted upon written or oral examination, waiver or National Board?.....
3. If by waiver, explain.....
4. For how long were you a resident of such state following issuance of license?.....
5. In what other states have you applied for license or registration?.....

(Specify State Board)	(Date of application)	(Result)	(Certificate number)	(Date issued)
Period of practice therein from....., 1.....				
(Specify if by examination or on credentials)				
to....., 1.....				
(Exact dates)				

(Specify State Board)	(Date of application)	(Result)	(Certificate number)	(Date issued)
Period of practice therein from....., 1.....				
(Specify if by examination or on credentials)				
to....., 1.....				
(Exact dates)				

6. Has any license entitling you to practice in any state or territory been suspended or revoked?..... If so specify: where?.....  
 (Specify state); when?.....; on what charge?.....  
(Give date) (Be specific)

7. Have you ever taken a written or oral examination in the State of Washington and failed?.....

STATE OF..... }  
 County of..... } ss.  
(Signature of applicant)

I, ....., being first duly sworn upon oath depose and say that the answers to the foregoing questions and the statements made in the above application for reciprocity are true and correct.

[Seal] .....  
(Signature of applicant)

Subscribed and sworn to before me this..... day of....., 19.....

Notary Public in and for the State of.....  
 Residing at.....

### CERTIFICATE

To be executed by the Secretary of the Board or Department of the State upon whose license the applicant relies for reciprocal registration in Washington.

I certify that the aforesaid..... in h..... examination before the  
(Full name of applicant)  
(Give title of Board or Department)

of this state attained a general average of..... per cent and the following marks in the subjects named:

Subjects	Per Cent	Subjects	Per Cent

I do further certify that a certificate to practice.....  
 was issued to said applicant on the..... day of....., 19....., upon the following qualifications:

and said certificate has not been revoked or suspended and that, from the records now on file in this office, I believe h..... to be of good moral character and worthy of professional recognition, and recommend h..... to the Division of Professional Licensing of the State of Washington as a fit and proper person to receive recognition as an applicant for a reciprocity certificate permitting h..... to practice.....

In testimony thereof, witness my hand and seal this..... day of....., 19.....

[Seal] .....  
 SECRETARY OF THE.....  
(State Board or Department)

Post Office Address.....

April 24, 1969

James E. M. Weyand, M.D.

Dear Doctor Weyand

Thank you for the medical application received in this office 4/18/1969.  
The next meeting of the medical board will be held on 6/12/1969,  
at which time your application will be reviewed. You will then be advised  
of board decision. Please allow at least two weeks.

Application appears complete

Lacks the following -

Internship certificate.  
State Board certification.  
Basic Science certification.  
National Board "Certification  
of Record".

Fee.  
Photograph.  
Medical School diploma.  
E.C.F.M.G. certificate.  
Medical School subjects.

Evidence of some experience in and a practical working knowledge of:  
1. Gynecology.                      2. Pathology.                      3. Obstetrics.

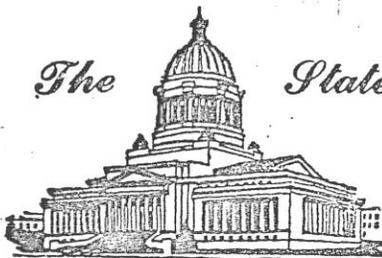
(Copies of all documents must be certified as true.)

Remarks: Thank you for the nicely completed application.

Very sincerely yours

Max V. Brokaw  
Administrator

By Lucille Disney  
Medical Section Supervisor



*The State of Washington*

**DIVISION OF PROFESSIONAL LICENSING**

P.O. BOX 649, OLYMPIA 98501

DANIEL J. EVANS,  
GOVERNOR

PROFESSIONS  
June 16, 1969

DOUGLAS TOMS  
DIRECTOR

James Elbert Mason Weyand

Dear Doctor Weyand:

We are pleased to advise that you have been issued Washington State Physician and Surgeon certificate No. 10775, dated 06-16-69. You will receive your wallet size license within a few weeks. Your medical certificate will be forwarded to you as soon as it is engraved and signed by members of the Board. This necessitates some delay and you will not receive the certificate for several weeks. It is important that you keep us advised of any change in your address so that the certificate will reach you safely.

This office will send you notification of your license renewal thirty days prior to due date, which is July 1st of each year.

Enclosed please find the law Defining and Regulating the Practice of Medicine and Surgery in the State of Washington.

Sincerely yours,

Max V. Brokaw  
Administrator

Lucille Disney  
Supervisor, Medical Section

APPLICATION FOR LICENSURE  
MEDICINE AND SURGERY

BOARD WORKSHEET

NAME WEYAND, JAMES G. M. DATE OF RECEIPT 4/18/1969

- 1) LICENSURE BY: COMMENTS
- a) National Board Waiver  \_\_\_\_\_
- b) Reciprocity From \_\_\_\_\_ state  \_\_\_\_\_
- c) Examination  \_\_\_\_\_
- 2) BASIC SCIENCE REQUIREMENTS
- a) National Board  \_\_\_\_\_
- b) Reciprocity From \_\_\_\_\_ state  \_\_\_\_\_
- c) Examination  \_\_\_\_\_
- d) Partial Examination  \_\_\_\_\_
- Subject(s) \_\_\_\_\_  \_\_\_\_\_
- 3) PROOF OF EDUCATIONAL EXPERIENCE
- a) College, University  \_\_\_\_\_
- b) Medical School  \_\_\_\_\_
- c) Internship  \_\_\_\_\_
- d) Chronology  \_\_\_\_\_
- e) Ob-Gyn-Path  \_\_\_\_\_
- 4) FOREIGN GRADUATE
- a) ECFMG  \_\_\_\_\_
- b) Medical School Subjects  \_\_\_\_\_
- 5) PERSONAL QUALIFICATIONS  \_\_\_\_\_
- 6) LETTERS OF RECOMMENDATION  \_\_\_\_\_
- 7) AMA CLEARANCE 4-23-69  \_\_\_\_\_
- 8) STATE CLEARANCE 4-23-69  Ohio \_\_\_\_\_
- 9) ADMINISTRATIVE RECOMMENDATION OK for license \_\_\_\_\_

BOARD ACTION:

DATE CONSIDERED 6-13-69  
REVIEWED BY \_\_\_\_\_

APPROVED     
DISAPPROVED   
OTHER

LICENSE  EXAM

*J. J. J.*

COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CERTIFIED FOR THE BOARD

*Ardenace Moll M.D.*

SECRETARY

BIOGRAPHICAL DATA ON PHYSICIANS  
 from the files of  
 The American Medical Association  
 535 No. Dearborn St.  
 Chicago, Illinois 60610

RECEIVED  
 APR 29 1969  
 RECEIVED  
 MAY 5 1969  
 PHYSICIANS' RECORDS SECT.

Department of  
 INVESTIGATION

To: Corresponding Officer of Medical Licensing Board:

This form is provided for your convenience in making routine inquiries regarding physicians seeking medical licensure in your state. Please enter on this form data you wish verified and mail to the Circulation and Records Department of the A.M.A. A check mark (✓) indicates that the data given corresponds to that which is in the historical files of the A.M.A.

Executive Officer's Name..... MAX V. BROKAW ..... Title..... ADMINISTRATOR .....

State..... WASHINGTON ..... City..... OLYMPIA ..... Date..... 4/24/1969 .....

Full name of licensure candidate (M.D.)..... WEYAND, JAMES GILBERT MASON .....

Place of birth..... ..... Date of birth..... .....

Mailing Address..... .....

Medical Education-School..... ..... M.D. Degree (Year).....  
 Western Reserve University ✓ ..... 1966 ✓

Internships Hospital Location Dates to  
 Virginia Mason Hospital ✓ Seattle, Wa. 6/24/66 to 6/24/67 ✓

Residencies Hospital Location Dates to  
 University Hospitals ✓ Seattle, Wa. 7/1/67 to 7/1/71 ✓

Applicant Licenced to Practice Medicine in the Following States:

State..... Ohio ✓ ..... Year..... 1966 .....; State..... ..... Year..... .....; State..... ..... Year..... .....

Present Application for Licensure

By Examination..... By Reciprocity..... State..... By Endorsement of Credentials..... N.B. 1967 ✓

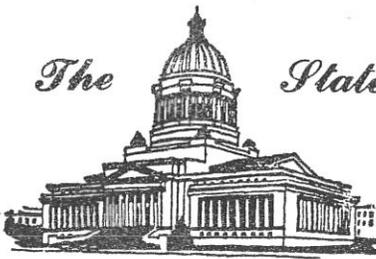
Department of Investigation

Our records do not reveal any derogatory information.

See attached memo for comments regarding applicant.

Date..... 5/7/69 .....

304-23  
 Robert A. Carlow, Director  
 Circulation and Records Department



The State of Washington

DIVISION OF PROFESSIONAL LICENSING

P.O. BOX 649, OLYMPIA 98501



DANIEL J. EVANS, GOVERNOR

PROFESSIONS April 24, 1969

DOUGLAS TOMS DIRECTOR

State Board of Medical Examiners of Ohio
21 W. Broad Street
Columbus, Ohio 43215

Gentlemen

We would appreciate knowing if you have any unfavorable information concerning the following physician who is applying for a license to practice medicine in Washington.

WEYAND, JAMES G. M.

Birth place and date:

School of graduation Western Reserve

Licensed: State(s) Ohio

Derogatory information or other remarks:

Dr. Weyand's license is free and clear. However, he failed to register for biennial renewal of his license, as now required by House Bill #418. An application was sent to Dr. Weyand but was returned with no forwarding address. Before he can be endorsed to another state, Dr. Weyand must submit the ten dollar fee for registration and a ten dollar penalty invoked for not registering by due date.

By M. Wolfe
Title Records Clerk

# NATIONAL BOARD OF MEDICAL EXAMINERS

3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

## CERTIFICATION OF RECORD

**To:** State of Washington - Division of Professional Licensing  
 Post Office Box 649  
 Olympia, Washington 98501

THIS CERTIFIES that James G. M. Weyand, Jr., M. D.  
 has successfully completed all examinations required for certification by the National Board of Medical Examiners and that his grades were as follows:

PART I		PART II		PART III	
Anatomy, including histology and embryology . . .	75	Internal medicine and the medical specialties . . .	81	A General Test of Clinical Competence	81.5
Physiology . . . . .	81	Surgery and the surgical specialties . . . . .	78		
Biochemistry . . . . .	86	Obstetrics and Gynecology . . .	82		
Pathology . . . . .	87	Public Health and Preventive Medicine . . . . .	81		
Bacteriology, including immunology . . . . .	84	Pediatrics . . . . .	75		
Pharmacology and Materia Medica . . . . .	84	Psychiatry . . . . .	88		

Part I passed June, 1965

Part II passed April, 1966

Part III passed March, 1967

General Average 81.8

Certificate No. 93719

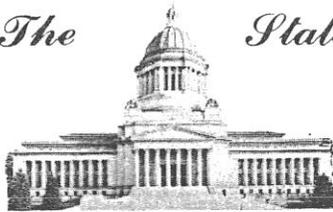
Certificate dated July 1, 1967

*John P. Hubbard, M.D.*  
 President

SEAL

April 8, 1969

Date



DIVISION OF PROFESSIONAL LICENSING

P.O. BOX 649, OLYMPIA 98501

DANIEL J. EVANS,  
GOVERNOR  
DOUGLAS TOMS  
DIRECTOR

PROFESSIONS

THOMAS A. CARTER  
ADMINISTRATOR

Division of Professional Licensing  
P.O. Box 649  
Olympia, Washington 98501

Sirs:

This is to verify that James G M Weyand, Jr M.D.,  
successfully completed a Rotating Internship  
at Virginia Mason Hospital Hospital, from  
24 June 1966 to 24 June 1967.

During this internship, a practical working knowledge of Obstetrics-  
Gynecology and Pathology was obtained.

George Hugh Lawrence MD  
Name

Director of Medical Education  
Title

Virginia Mason Hospital  
Hospital

Re: RCW 18:71:050

# Virginia Mason Hospital

Seattle



Washington

This Verifies That

James S. M. Meyand, Jr., M.D.

Has satisfactorily completed a term of service in this Hospital as  
**Rotating Intern**

from June twenty-fourth, nineteen hundred and sixty-six to  
June twenty-third, nineteen hundred and sixty-seven.

*Richard F. Jones*  
President

*James S. Meyand, Jr.*

*George Hugh Sawyer*  
*Executive Director*

State of Washington  
County of King

CERTIFIED TRUE COPY.

*Monica M. Sullivan*  
Secretary

April 11, 1969

# WESTERN RESERVE UNIVERSITY

TO ALL TO WHOM THESE LETTERS COME GREETING

ON THE RECOMMENDATION OF THE FACULTY OF

THE SCHOOL OF MEDICINE

THE TRUSTEES OF THE UNIVERSITY HAVE ADMITTED

JAMES GILBERT MASON WEYAND JR.

TO THE DEGREE OF

DOCTOR OF MEDICINE

UPON COMPLETION OF THE REQUIREMENTS

PERTAINING TO THIS DEGREE

GIVEN AT CLEVELAND OHIO JUNE FIFTEENTH

NINETEEN HUNDRED SIXTY SIX



*John Schuff Miller*  
PRESIDENT  
*Mary Carolyn Hoff*  
SECRETARY

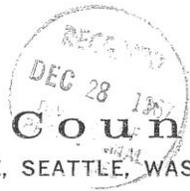
*Dauphin Sanford Bond*  
DEAN

State of Washington  
County of King

Certified true copy.

*Nancy Ann Twelker*  
Notary Public

April 11, 1969



Weyand  
J G M

King County Hospital  
325 9th AVENUE, SEATTLE, WASHINGTON 98104 • MUTual 2-3050

James G M Weyand M

Dept. of Prof. Licensing  
Medicine Division  
State Capitol Bldg  
Olympia, Wash.

Dear Sirs:

Would you please send me the necessary forms for application for medical licensure.

I presently hold an Ohio STATE Board license (1966) and have completed and passed the National Board Examinations, Parts I, II and III.

Thank you.

12 29 64

Exp  
Off  
C. J. P.

Sincerely yours

James G M Weyand, M.D.