RECEIVED

MAY 20 2016

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Medical School Verification (UA Form #2)

Applicant: Complete this form as instructed in the left sidebar.
Dean or Designated Med School Official: Complete as instructed in the left sidebar. KSBHA

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

Section 1: Applicant Information

Last name: CHIAVARINI Suffix: _____

First name: ANDREA

Middle name: HARRELL

Name if different when diploma awarded: _____

Name of medical school: OREGON HEALTH AND SCIENCE UNIVERSITY

Date of birth: [redacted]-1974 Social Security number*: [redacted]

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: [signature] **Date:** 5/13/16

Dean or Designated Official:

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the Kansas State Board of Healing Arts at the address listed in Section 1. Do not mail this form to FCVS/FSMB.

If transcripts are not in English, an original, certified, and official English translation is required.

Section 2: Medical School Verification

Medical school name: OREGON HEALTH + SCIENCE UNIVERSITY

School name if different when the above applicant attended: _____

Medical school address (including city, state or province, zip code, and country as applicable):
FINANCIAL AID AND REGISTRARS OFFICE L109
~~OREGON HEALTH & SCIENCE UNIVERSITY~~
3181 S.W. SAM JACKSON PARK ROAD
PORTLAND, OREGON 97239

Hours of undergraduate education required for admission into your school: 4 YRS UNDERGRAD

Total weeks of education applicant attended your school: 161

Applicant's attendance dates: From 9/1/99 to 6/4/03

Graduation date: 6/4/03 (indicate N/A if not applicable) Degree: M.D. (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) 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.

RECEIVED
MAY 20 2016

Applicant Name: ANDREA HARRELL CHTAVARINT

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes ☐ KSBHA No ☑

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

		From Month/Year	To Month/Year	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)			☐	☐
☐	Other: _____			☐	☐

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? 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 documentation/information of the circumstances and outcome(s).

		From Month/Year	To Month/Year
☐	Academic probation		
☐	Probation for unprofessional conduct/behavioral reasons		
☐	Probation for other reason(s) (please specify):		

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

   If yes, please attach documentation/information of the circumstances and outcome(s).

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

   If yes, please attach documentation/information of the circumstances and outcome(s).

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes ☐ No ☑

   If yes, please attach documentation/information of the nature of the limitations or special requirements.

Seal Verified KSBHA

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Signature: Gerri Chanti

Print name: GERRI CHANTI

Title: ADMIN. COORD

Date: 5/13/16

Phone number: 503-494-7600 Fax number: 503-494-4629

Email: REGOHSU@OHSU.EDU

OREGON HEALTH & SCIENCE UNIVERSITY

To all whom this writing may come, Greetings:

Be it known that

Andrea Harrell Chiavarini

having successfully completed the prescribed course of study and having complied with all other requirements established by the University, has been declared a

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 4th day of June, A.D., 2003.

Peter O. Kohler
President, Oregon Health & Science University

Frederick W Buckman
Chairman of the Board

Dean, School of Medicine

Bailey M. Dallick
Provost

RECEIVED
JUN 1 2016
KSBHA

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.
Program Director or Designated Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

Section 1: Applicant Information

Last name: CHIAVAMINI Suffix: _____

First name: ANDREA

Middle name: HARRELL

Name if different when diploma awarded: _____

Name of postgraduate training program: UNIVERSITY OF ARIZONA

Date of birth: [redacted] 1974 Social Security number*: [redacted]

The social security number is to be used for purposes of identification only and may not be used for any other reason.

Waiver for Release of Information: I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: [signature] **Date:** 5/13/16

Dean or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

Section 2: Postgraduate Training Verification

Institution name: University Of Arizona

Institution address: 1501 N. Campbell, Box 245078

Institution city / state or province / zip code: Tucson, AZ 85724

Affiliated medical school name: University of Arizona

Institution / school name if different when the applicant attended: _____

Postgraduate year (e.g., 1, 2, 3, etc.): 1 ☒ Internship ☐ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: OB/GYN

Attendance dates: From July 1, 2003 to June 30, 2004

Successfully completed*? ☒ Yes ☐ No ☐ In progress with expected completion date of _____

In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

RECEIVED
JUN 1 2016
KSBHA

Applicant Name: ANDREA HARRELL CHIAVARINI

Postgraduate year (e.g., 1, 2, 3, etc.): 2-4 ☐ Internship ☒ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: OB/Gyn

Attendance dates: From July 1, 2004 to June 30, 2007

Successfully completed*? ☒ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

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

Soal Verified KSBHA

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Signature: _____
Print name: Amy L. Mitchell, MD
Title: Program Director
Date: 5/20/16
Phone number: 520-626-6636 Fax number: 520-626-1446
Email: Amymitch@obgyn.arizona.edu

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, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Recipient: KANSAS STATE BOARD OF HEALING ARTS

Date: 05/13/2016

Examinee: Chiavarini, Andrea Harrell

Examinee ID: 50918671

Alt Name(s): Harrell, Andrea Lynne

Date of Birth: [redacted]1974

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, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
6/7/2001	Pass	[redacted]		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
12/17/2002	Pass	[redacted]		

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
3/5/2007	Pass	[redacted]		

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

Oregon
John A. Kitzhaber, MD, Governor

Medical Board
1500 S.W. 1st Ave., Suite 620
Portland, OR 97201
Voice (971) 673-2700
FAX (971) 673-2670
Web: www.oregon.gov/OMB

Verification of Licensure

May 12, 2016

This is to certify that the records of the Oregon Medical Board indicate the following information regarding:

Licensee:	Chiavarini, Andrea Harrell, Dr.
Birth Year:	1974
Gender:	Female
Mailing Address:	[redacted] Portland, OR 97217
Basis of Licensure:	USMLE
School:	Oregon Hlth & Science Univ
School Location:	Portland, OR, United States
Graduation Date:	06/04/2003
*Disciplinary Standing:	Unrestricted
License Number:	MD27441
Status:	Active
Status Limitations:	
Date Issued:	05/07/2007
Expiration Date:	12/31/2017
License Type:	MD License
Expedited Endorsement:	No
Specialty:	Obstetrics and Gynecology
Dispensing Physician:	No

** Please read explanation below*

**** IMPORTANT - PLEASE READ***

- "Disciplinary Standing" refers to whether or not the Oregon Medical Board has ever taken a formal action against a Licensee. Such actions are taken via a document called a Public Order. If the "Disciplinary Standing" field above says "Public Order on File," "Prior Action," or "Revoked," it means that the Board has taken formal action against this Licensee and your Board is entitled to receive free copies of all related Public Orders. These orders will be sent to you directly by the Oregon Medical Board via US mail within 2-4 working days from the date of this verification.
- If the "Disciplinary Standing" field says "Unrestricted," that means that the Board has never taken any formal action against the Licensee in question and, as a result, there are no Public Orders on file.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
P.O. Box 47866, Olympia, WA 98504-7866

May 12, 2016

KANSAS STATE BOARD OF HEALING ARTS
800 SW JACKSON
TOPEKA, KS 66612

Subject: Credential Verification

To Whom It May Concern:

This will verify the status of the Physician And Surgeon License for ANDREA CHIAVARINI.

You may see blank sections because we do not have the information in our database or it is not applicable for this credential type. This information is valid from the date of this letter.

Year of Birth:	1974
Credential Number:	MD,MD60170852
Credential Type:	Physician And Surgeon License
Current Credential Status:	ACTIVE
First Credential Date:	07/08/2010
Current Expiration Date:	10/22/2016
Last Renewal Date:	09/19/2014
DISCIPLINARY ACTION:	No

This license information was last updated on: 05/07/2016

If you have questions, please call (360)-236-2768 for physicians and (360) 236-2771 for physician assistants, or visit our Online Provider Credential Search at www.doh.wa.gov.

Dawn Thompson

Dawn Thompson, Licensing Lead

RECEIVED
MAY 17 2016
KSBHA

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this notarized form to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to:

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level - Suite A
Topeka, KS 66612

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of 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 Uniform Application for Physician State Licensure 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 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 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 any of its 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, 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 the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

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

CHIAVARINI
Applicant's printed last name

ANDREA, H
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

05/11/2016
Date of signature (must correspond to date of notarization)

fold up — fold up

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of Oregon, County of Multnomah,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant 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.

The statements on this document are subscribed and sworn to before me by the applicant on this 11 day of May, 2016.

Notary Public Signature: _____ (NOTARY PUBLIC SEAL)

My Notary Commission Expires: 9/2/2019

OFFICIAL SEAL
BRYCE FONG SAETEURN
NOTARY PUBLIC - OREGON
COMMISSION NO. 942478
MY COMMISSION EXPIRES SEPTEMBER 02, 2019

Kansas State Board of Healing Arts

Addendum 1

Discipline applying for (check appropriate item):

RECEIVED
MAY 20 2016
KSBHA

☒ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

License Designation: Please select the license designation you are requesting.

☒ **Active** A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

☐ **Federal Active** A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ **Inactive** A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

☐ **Exempt** A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect. List intended professional activities: _____

Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☒ No
2. Give location of intended practice in Kansas Southwind Women's Center - Wichita
3. Primary Specialty Obstetrics & Gynecology

   American Board Certified yes - ABOG American Board Eligible _____

Statement of Health:

4. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your particular branch of the healing arts or your particular specialty? ☒ Yes ☐ No

   If yes, applicant shall file with this application, a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

Name (Printed or Typed): Andrea Chiavarini **Date:** 5/18/16

Kansas State Board of Healing Arts

RECEIVED
MAY 20 2016
KSBHA

Addendum 2

Please answer each of the following questions by putting a check (✓) in the appropriate box. All "yes" answers MUST be thoroughly explained in detail in a separate signed page. You are required to furnish complete details including date, place, reason and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.

If you are unsure of your response to a particular question, check (✓) the "yes" box and submit the appropriate form if required. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check (✓) the "no" box. It is your continuing duty to update the Board on any changes once the application has been submitted.

1. ☐ Yes ☑ No Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training or educational program, including but not limited to medical school, prior to completing the training?

2. ☐ Yes ☑ No Have you ever had any application for any professional license refused or denied by any licensing authority?

3. ☐ Yes ☑ No Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?

4. [redacted] Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

5. ☐ Yes ☑ No Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

6. ☑ Yes ☐ No Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?

7. ☐ Yes ☑ No Have you ever voluntarily surrendered any professional license?

8. ☐ Yes ☑ No Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation, or had any other disciplinary action taken against any professional license you have held?

9. ☐ Yes ☑ No Have you ever been notified or requested to appear before a licensing or disciplinary agency?

10. ☐ Yes ☑ No To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?

Name (Printed or Typed): Andrea Harrell Chiavarini **Date:** 5-18-16

RECEIVED
MAY 20 2016
KSBHA

Addendum 2 (continued)

11 ☐ Yes ☑ No Has any professional association imposed any disciplinary action against you?

12. [redacted] Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?

13. [redacted] Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?

14. [redacted] Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?

15. [redacted] Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?

16 [redacted] Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?

17. ☐ Yes ☑ No Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?

18. ☐ Yes ☑ No Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?

19. ☐ Yes ☑ No Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?

20. ☐ Yes ☑ No Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

21 ☐ Yes ☑ No Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

22. ☐ Yes ☑ No Have you ever been court-martialed or discharged dishonorably from the armed services?

23. ☑ Yes ☐ No Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself?

24. ☐ Yes ☑ No Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?

25. ☐ Yes ☑ No Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company?

Name (Printed or Typed): Andrea Harrell Chiavarini **Date:** 5-18-16

ADDENDUM 3

RECEIVED

MAY 17 2016

KSBHA

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): Andrea Chiavarini **Date of Birth:** [redacted]1974

Please mail this document to the Kansas State Board of Healing Arts at the address above.
Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. Andrea Chiavarini MD (type or print) for 5+ years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. Andrea ChiavarinidMD is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Jennifer Mahnke MD

Street 1: 700 NE 87th Ave

Street 2: (The Vancouver clinic)

State/Zip: Vancouver, WA 98683

Telephone: (360) 882-2778

Signature: Jennifer Mahnke MD

Date: 5/11/16

ADDENDUM 3

RECEIVED

MAY 16 2016

KSBHA

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): Andrea Chiavarini **Date of Birth:** [redacted] 1974

Please mail this document to the Kansas State Board of Healing Arts at the address above.
Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. Chiavarini (type or print) for 16 years; that he/(she) is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. Chiavarini is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Jane van Dis, MD

Street 1: 200 W Terrace St.

Street 2:

State/Zip: Altadena CA 91001

Telephone: 310 254 7023

Signature: [signature]

Date: 5/10/16

ADDENDUM 5

RECEIVED
MAY 20 2016
KSBHA

Kansas

WAIVER AGREEMENT AND STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize the Kansas State Board of Healing Arts to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the Purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. Pursuant to K.S.A. 22-4701 *et seq.* and K.S.A. 22-5001, the Kansas State Board of Healing Arts may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the Kansas State Board of Healing Arts of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Kansas State Board of Healing Arts may choose to deny my application or grant me a limited or restricted license until the criminal history background check is completed.

I understand that, upon my request, the Kansas State Board of Healing Arts will provide me with a summary of the information contained in my Criminal History Background Report for the limited purpose of challenging the accuracy and/or completeness of the information contained in the report, but will not provide me with a complete copy of the Criminal History Background Report. I understand that I may obtain a prompt determination as to the validity of my challenge before the Kansas State Board of Healing Arts makes a final decision about my application for license to practice the healing arts. I further understand that I will not be provided access to information in my Criminal History Background Report under the following circumstances: 1) I am granted a full, unrestricted license, 2) I voluntarily withdraw an application for licensure, or 3) I am denied a license and have exhausted all my right to appeal the denial.

I have ☐ OR have not ☒ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

_____

_____

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 3805, and may result in the denial of my application pursuant to K.S.A. 65-2836 (a).

Signature: [signature] Date: 5/18/16

Printed Name: Andrea Chiavarini Date of Birth: [redacted] 1974

Residential Address: [redacted] City: Portland State: OR Zip: 97217

800 SW Jackson, Lower Level, Suite A, TOPEKA, KS 66612
Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

ADDENDUM 6

RECEIVED
MAY 20 2016
KSBHA

Kansas

AUTHORIZATION AND RELEASE INFORMATION

Please complete if you would like for Board staff to talk with others concerning your application.

I, Andrea Chiavarini, hereby authorize the Kansas State Board of Healing Arts ("Board")
print name

to release and discuss any and all information pertaining to my application pending before the Board with the following individual(s):

Name of Individual / Phone number	Relationship to Individual
Liz Lococo, LMHC, CDP 1-800-552-7236	Clinical Coordinator at Washington Physicians Health Program

I understand that this Authorization and Release may be revoked only in writing. A reproduction of this Authorization and Release shall have the same effect as the original.

Signature

5/18/16
Date