

To the Board of Medical Examiners of the state of New Mexico:



I hereby make application for a license to practice medicine and surgery in the State of New Mexico and submit the following statement concerning my age, moral character, and medical education and practice.

- 1. Name in full JAN EUGENE WHITEFIELD <sup>4/81: 916 SOLANO, NE</sup> <sub>ALB, NM 87110</sub>
- 2. Address [REDACTED] ALBUQUERQUE, N. MEX 87106
- 3. Place and date of birth 1/45 ROCHESTER, PA.
- 4. American citizen (by birth or naturalization) By Birth - YES

If not a citizen Declaration of Intention - Date filed and No. \_\_\_\_\_

5. I have practiced medicine and surgery by virtue of a permanent license or certificate issued by a duly constituted Board of Medical Examiners 0 years, as follows:

- From \_\_\_\_\_ To \_\_\_\_\_ at \_\_\_\_\_
- From \_\_\_\_\_ To \_\_\_\_\_ at \_\_\_\_\_
- From \_\_\_\_\_ To \_\_\_\_\_ at \_\_\_\_\_
- From \_\_\_\_\_ To \_\_\_\_\_ at \_\_\_\_\_

6. I am a member of the following Medical Societies or Associations NONE

7. Upon what license or certificate do you base this application? M.D. UNM SCHOOL OF MEDICINE 5/80

8. In what states licensed? NONE

9. On what hospital staffs have you served in the past 5 years. (give names and addresses.)  
NONE

10. Have you any physical impairment? No (If yes use separate page to explain.)

11. Have you ever been hospitalized or otherwise treated for mental illness? No (If yes use separate page to explain.)

12. Have you ever resigned or withdrawn your application from any hospital staff or other professional group?  
No

13. Have you ever been denied a certificate or the privilege of taking an examination before any State Medical Examining Board? No If yes, which one and why? (use separate page to explain)

14. Has any State Medical Examining Board ever taken disciplinary action against you? No

15. Have you ever had any personal or legal problems with narcotics, alcohol or other dangerous drugs? No (If yes use separate page to explain)

16. Have you ever been charged with violation of any Federal, State or Local Statute? (Explain) \_\_\_\_\_

✓ YES: SHOPLIFTING, 1966 - FILED #20  
(except for minor traffic violation)

17. Has disciplinary action ever been taken against you by a hospital staff or by any County Medical Society? No  
(Explain) \_\_\_\_\_

18. Are you Board No Certified? \_\_\_\_\_ By what Board? \_\_\_\_\_

19. Military Service (dates) AIR FORCE 1969-1973 (attach certified copy of Discharge)

**INTERNSHIP**

DAY, MONTH, YEAR	DAY, MONTH, YEAR	NAME OF HOSPITAL	LOCATION
From <u>NONE</u>	To _____	_____	_____

DAY, MONTH, YEAR

DAY, MONTH, YEAR

NAME OF HOSPITAL

LOCATION

From NONE To .....

From ..... To .....

From ..... To .....

I received the degree of M.D. from UNIVERSITY OF NEW MEXICO located at A. B. QUERQUE, N. Mex. on the 18 day of MAY, 1980

I am the person named in the diploma submitted and am the lawful possessor of same. The photograph attached hereto is a true likeness of myself and was taken within six months prior to the date of this application.

Dated 5/27/80 Signed Jan Eugene Whitefield

Address 1129 PRINCETON DR. NE. ALB., N. Mex

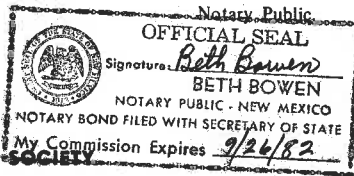
County of Bernalillo State of N. Mexico

In Bernalillo said county on this 27 day of May

A.D. 1980, personally appeared before me Jan Eugene Whitefield who, being duly sworn, deposes and says that he has read carefully and truthfully answered the above questions and that every statement recorded above is true and correct.

Beth Bowen

My commission expires September 26, 1982



**CERTIFICATION OF COUNTY MEDICAL SOCIETY**

State of ..... }  
County of ..... } ss

\* ....., M.D., President of the ..... County Medical Society, State of .....

....., M.D., Secretary of the ..... County Medical Society, State of .....

Being duly sworn upon oath and say, each for himself that he has known, or investigated said ..... M.D., and knows h..... to be of good moral and professional character, that he has been in practice of medicine or has interned at ..... for the past ..... years, that he recommends h..... as being worthy and well qualified for a Physician's and Surgeon's license to practice in the State of New Mexico.

....., M.D., President of the ..... County Medical Society, State of .....

....., M.D., Secretary of the ..... County Medical Society, State of .....

Subscribed and sworn to this ..... day of ....., 19..... (SEAL)

Notary Public.

My Commission expires .....

It is hereby certified that Jan E. Whitefield  
of Albuquerque, New Mexico Matriculated in  
U. of New Mexico School of Medicine at Albuquerque, New Mexico  
Date 13 August 1976, attended all required courses of instruction  
of four years months each, and received a diploma conferring the degree of Doctor of Medicine  
(date) 18 May 1980  
Date 27 May 1980

*Leonard Repitans*  
(President, Secretary or Dean)

(SEAL)

**CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE  
OR NATIONAL BOARD OF MEDICAL EXAMINERS**

I, \_\_\_\_\_, Secretary of \_\_\_\_\_  
\_\_\_\_\_ certify that  
\_\_\_\_\_ was granted certificate  
No. \_\_\_\_\_ to practice medicine in the State of \_\_\_\_\_  
on the \_\_\_\_\_ day of \_\_\_\_\_ 19 \_\_\_\_\_ based on \_\_\_\_\_  
and that said certificate has never been revoked. (Written examination or diploma)

Did applicant pass the Federation Licensing Examination? \_\_\_\_\_

If by written examination the secretary should further certify:

I further certify that the aforesaid \_\_\_\_\_  
in his written examination before this Board, obtained a general average of \_\_\_\_\_ per cent in the following  
subjects:

SUBJECT	PER CENT	SUBJECT	PER CENT

Acting on behalf of the \_\_\_\_\_  
I hereby certify to the reputability of Dr. \_\_\_\_\_  
based on the records, and recommend him to the Board of Medical Examiners of the State of New Mexico as a fit  
and proper person to receive a certificate. (If application is from \_\_\_\_\_)

**APPLICATION FOR LICENSE THROUGH  
ENDORSEMENT OR EXAMINATION**

Issued by the  
**MEXICO BOARD OF MEDICAL EXAMINERS**

JAN WHITEFIELD  
1129 PRINCETON DR N.E.  
ALBUQUERQUE, N.MEX. 87106  
Application Received 6/5/80  
\$100.00 Paid 4/20/81 #6074 Receipt  
Fingerprints Received 4/20/81  
Application Approved  
License Granted 11-16-81  
License No. 81-341  
Physical Appearance  
Temporary License Granted  
Temporary License No.

Two recent unmounted photographs of applicant 3x5 inches must be furnished with this application. One to be pasted in space below—the other with name and address on back in applicant's own handwriting.



**RULES GOVERNING LICENSURE**

Every applicant for licensure in this State, whether by examination or endorsement of another State Board of Medical Examiners, or National Board of Medical Examiners must have a diploma from a medical college as defined by New Mexico law.

The Board holds regular meetings at Santa Fe on the third Monday in May and November each year. Permanent licenses can be renewed at regular meetings of the Board. The Secretary may grant a temporary license until the next regular meeting of the Board, to a qualified applicant by endorsement.

The fee for licensure by endorsement or by examination is \$100.00. It must be paid by MONEY ORDER OR CASHIER'S CHECK. NEITHER PERSONAL CHECKS CAN BE ACCEPTED. THIS FEE IS NOT REFUNDABLE.

An applicant for licensure by endorsement or examination must complete the application in every detail and file it with the Secretary. A photostatic copy of the application must be filed with the Secretary. A photostatic copy of the affidavit on the back stating that he is the possessor of same and is true and correct is required as is completion of fingerprint chart. A graduate of medical school will also file a certified translation of his diploma when necessary. A copy of his permanent certificate from the Educational Council for Professional Graduates.

All applicants must be American Citizens or have filed Declaration of Intention of becoming a citizen.

A personal interview with the Secretary of the Board of Medical Examiners is required before a temporary license can be granted. Before a candidate is granted a permanent license by endorsement or examination he must appear at a regular meeting.

Completed application must be filed with the Secretary not less than SIX WEEKS before a regular meeting, or SIX WEEKS before examination.

return not complete



# BOARD OF MEDICAL EXAMINERS RENEWAL APPLICATION FOR LICENSE TO PRACTICE MEDICINE

ALL information (unless noted) must be supplied.

INCOMPLETE FORMS WILL BE RETURNED WITHOUT BEING PROCESSED.

The fee of \$50 must be received by the Board before December 31, 1987. IF YOU DO NOT RENEW YOUR LICENSE BY DECEMBER 31, 1987 YOUR NAME WILL NOT BE INCLUDED IN THE 1988 MEDICAL DIRECTORY PUBLISHED BY THE BOARD.

(\$10 will be applied to the Impaired Physician Monitored Treatment Program created by Chapter 204 during the 1987 session of the Legislature.)

\*\*\*PLEASE PRINT OR TYPE\*\*\*

\*\*\*\*\*

ORIGINAL NM LICENSE # 81-341

NAME AS IT APPEARS ON YOUR CURRENT LICENSE

WHITEFIELD JAN E  
Last Name First Name Middle Initial

MAIDEN NAME



DATE OF BIRTH 4/5 SOCIAL SECURITY #   
Month Day Year

BUSINESS ADDRESS (Not a P.O. Box)

(Law 61-6-23 states that a Certificate of annual registration shall be at all times displayed conspicuously in the office of the practitioner to whom it has been issued.)

2740 LAKE OTIS Parkway  
Street  
Anchorage Alaska 99508  
City State Zip

PHONE NO. (907) 258-6162

Any practitioner who changes the location of his office or residence shall, before doing so, notify the Board of such change.

HOME ADDRESS

PHONE NO.

Street  
  
City State Zip

BOARD CERTIFIED [ ] Yes [X] No

SPECIALTY OB/Gyn

OBG

**MEDICAL SCHOOL** Name UNIV. OF New Mexico  
Address Albuquerque, N Mex  
Date of Graduation 6/80

**CURRENT HOSPITAL AFFILIATIONS**

1. Providence Hospital, Anchorage, AK
2. Humana Hospital, Anchorage, Alaska
3. \_\_\_\_\_
4. \_\_\_\_\_

Do you have any physical or mental conditions which would impair your ability to practice medicine? [ ] Yes [X] No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been convicted of a felony? [ ] Yes [X] No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

**FAILURE TO PAY THE RENEWAL REGISTRATION FEE IN A TIMELY MANNER (AS PER 61-6-28) MAY RESULT IN A PHYSICIAN BEING SUSPENDED FROM THE PRACTICE OF MEDICINE.**

Has any form of disciplinary action been instituted against you by any licensing authority, professional organization, medical institution or any other medically related entity? [ ] Yes [X] No

If yes, you must provide complete details of the disciplinary action with your renewal.

**STAPLE YOUR CHECK AND ANY ATTACHMENTS TO THE FORM.**

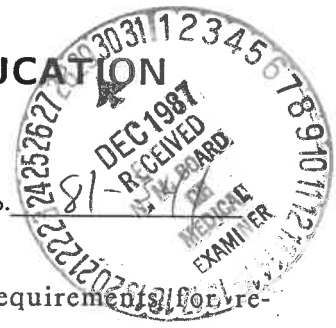
12/12/87  
Date

*Jan A. Whitefield*  
Signature of Physician

**RETURN RENEWAL FORM AND ATTACHMENTS TO:**

**Board of Medical Examiners  
PO Box 20001  
Santa Fe, NM 87504**

NEW MEXICO BOARD OF MEDICAL EXAMINERS  
VERIFICATION OF CONTINUING MEDICAL EDUCATION  
(61-6-3E/61-6-22 NMSA 1978 and NMBME Rule 79-13)



Print Name JAN E. WHITEFIELD License No. \_\_\_\_\_

I certify that I have completed the Continuing Medical Education requirements for re-registration of my license in 1988 as follows:

Required Education Category I during 1985, 1986, 1987: Credit Hours 75

- Physicians Recognition Award of AMA Year \_\_\_\_\_ Credit Hours \_\_\_\_\_
- Certificate of CME of AAFP: Year \_\_\_\_\_ Credit Hours \_\_\_\_\_
- Certification or Recertification by a Specialty Board Year \_\_\_\_\_ Credit Hours \_\_\_\_\_
- FLEX Component II: Year \_\_\_\_\_ Credit Hours \_\_\_\_\_
- Internship, Residency or Fellowship:

\_\_\_\_\_/\_\_\_\_\_  
Program Location / Dates Credit Hours \_\_\_\_\_

- Advanced Degree: Credit Hours \_\_\_\_\_
- Medical School \_\_\_\_\_

- Self Assessment Tests: Credit Hours \_\_\_\_\_
- Prolog - Am College OB/GYN Educational Institution Credit Hours 35

- Teaching: Credit Hours \_\_\_\_\_
- UNIV OF WASHINGTON Seattle at Anchorage AK Medical School or Approved Program Institution EXTENSION Credit Hours 47

- Preceptors: Credit Hours \_\_\_\_\_
- UNIV. OF WASHINGTON Seattle at Anchorage Medical School Alaska EXTENSION Credit Hours 48

- Scientific Paper or Publications: Credit Hours \_\_\_\_\_

TOTAL CREDIT HOURS 158

Date 12/20/87

Signature Jan E Whitefield

**IMPORTANT:**

Those physicians receiving a continuing education YELLOW form must remit ALL CERTIFICATES AND OTHER VERIFYING DOCUMENTS of attendance for all meetings, etc. attended that fulfill the requirements for relicensure.

YOUR FEE IS NOT REFUNDABLE IF YOU DO NOT MEET THE CME REQUIREMENT!

To: N.M. Board of Medical Examiners

From: Jan Whitefield  
N.M. License #81-341

12/20/87

Dear M. Bil Schmidt:

This is a letter to clarify the enclosures accompanying this letter.

I have taken several Category I clinical courses, some of which are documented below. I am only claiming those courses for which I have enclosed documentation.

3/15/85	Post Grad course-Lasers in Ob/Gyn	25 Credits
	(See enclosed transcript from ACOG)	
8/9/85	Summer Up Date-Ob/Gyn	13 Credits
8/7/87	Summer Up Date-Ob/Gyn	6 Credits
9/21/87	Beyond 16 Weeks	12 Credits
11/21/87	Tenth Annual Review Course In Clinical Ob and Gyn Histopathology	44 Credits

In addition, I am on clinical faculty of the University of Washington School of Medicine, Anchorage, Alaska, and have been delivering lectures to the medical students doing Ob/Gyn rotations in Alaska. I do three lectures of 1-3 hours length every 6 weeks, and have done this for just over two years for approximately 48 hours of clinical teaching.

Finally, the transcript from the ACOG verifies that I have completed two units of the Prolog published by the ACOG for an additional 50 credits, for which I can claim 35 credits.

Thus, I am sending documentation for 75 hours of Clinical courses, 48 hours of teaching, and 35 hours of self-assessment exams, for a total of 158 hours.

If additional documentation is needed, please let me know.

Sincerely,



Jan Whitefield, M.D., Ph.D.



# THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

## PROGRAM FOR CONTINUING PROFESSIONAL DEVELOPMENT



COGNATE PROGRAM  
A.C.O.G.

600 MARYLAND AVENUE S.W.  
WASHINGTON, D.C. 20024

TRANSCRIPT

ACOG ID NUMBER CF-0270924

PAGE NO.

1

JAN EUGENE WHITEFIELD M.D.

COGNATES REPORTED THROUGH MAR 15 1987

DATE OF ISSUE 04/17/87

AWARD COGNATES

FINDER # (OFFICE USE ONLY)	DATE	CODE	DESCRIPTION	CYCLE	CREDITED COGNATES	ADDITIONAL COGNATES	AWARD COGNATES		
							FORMAL CAT. I	INFORM. CAT. II	CONT. CAT. I
41121-000	11/17/84	01	POSTGRAD COURSE/SPECIALTY MEET	11	16	0	16	0	0
50812-000	07/31/85	03	PROLOG	11	25	0	41	0	0
50829-000	08/29/85	03	PROLOG	11	25	0	66	0	0
51121-000	10/22/85	32	PRESENTATION AT SCIENTIFIC MTG	11	5	0	66	0	5
60619-000	03/15/86	01	POSTGRAD COURSE/SPECIALTY MEET <i>↑ Laser course</i>	11	25	0	91	0	5

SUMMARY OF COGNATES FOR PRIMARY CYCLE **11**

REPORTING YEARS	CAT. I	CAT. II	CAT. III	TOTAL
84	16	0	0	16
85	50	0	5	55
86	25	0	0	25
<b>TOTAL COGNATES THIS CYCLE</b>				<b>96</b>

SUMMARY OF COGNATES FOR SECONDARY CYCLE **14**

REPORTING YEARS	CAT. I	CAT. II	CAT. III	TOTAL
87	0	0	0	0
88	0	0	0	0
89	0	0	0	0
<b>TOTAL COGNATES THIS CYCLE</b>				<b>0</b>

NOTE: AS OF JAN. 1, 1979, THE COGNATE HAS BEEN AWARDED ON AN HOUR-FOR-HOUR BASIS, THIS TRANSCRIPT REPRESENTS COGNATES REPORTED BY THE PHYSICIAN TO THE PROGRAM FOR CONTINUING PROFESSIONAL DEVELOPMENT



**PROVIDENCE HOSPITAL**


3200 Providence Drive • Pouch 6604 • Anchorage, Alaska 99502 • (907) 562-2211

**CENTER FOR EDUCATIONAL DEVELOPMENT  
CONTINUING MEDICAL EDUCATION PROGRAM  
Verification of Attendance**

*Name of Physician:* \_\_\_\_\_ Jan E. Whitefield, MD

*Program Title:* \_\_\_\_\_ Summer Update OB GYN *Date:* Aug. 8-9, 1985

*This program is acceptable for <sup>13</sup> hours Category 1  
and applies to the Physicians' Recognition Awards Program  
of the American Medical Association*

  
\_\_\_\_\_  
Mark E.N. Agnew, M.A., M.B., M.R.C.G.P.  
Director of Medical Staff Education

*This record should be used for your documentation of  
Continuing Medical Education hours.*



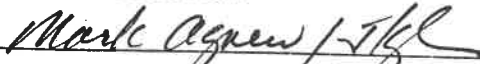
PROVIDENCE HOSPITAL  
SERVING ALASKA SINCE 1902

CENTER FOR EDUCATIONAL DEVELOPMENT

CONTINUING MEDICAL EDUCATION PROGRAM  
Verification of Attendance

Name of Physician: JAN E. WHITEFIELD, M.D.  
Program Title: Summer Update Conference In Obstetrics and Gynecology Date: Aug. 6&7, 1987

*This program is acceptable for 6 hours Category 1  
and applies to the Physicians' Recognition Awards Program  
of the American Medical Association*

  
Mark E.N. Agnew, M.A., M.B., M.R.C.G.P.  
Director of Medical Staff Education

*This record should be used for your documentation of  
Continuing Medical Education hours.*

*Certificate  
of  
Attendance*



*National Abortion Federation*

BEYOND SIXTEEN WEEKS

SEPTEMBER 20-21, 87

*This Certifies the Attendance of*

Jan Whitefield

*NAF is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.*

*The National Abortion Federation designates this continuing medical education activity for 12 credit hours in Category 1 of the Physicians Recognition Award of the AMERICAN MEDICAL ASSOCIATION.*

*This course has been approved for 12 cognates, Formal Learning, by the AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS.*

*B. REINFORD*

*Executive Director  
National Abortion Federation*

*President  
National Abortion Federation*

## CERTIFICATE OF COURSE COMPLETION

### PARTICIPANT INFORMATION

SOCIAL SECURITY  
NUMBER



NAME

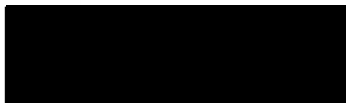
WHITEFIELD

LAST

JAN E.

FIRST

ADDRESS



STREET

Anchorage

CITY

AK

STATE

99504

ZIP

LICENSE TYPE  
(i.e. M.D., R.N., L.V.N.)

M.D.

MMC EMPLOYEE

### PROGRAM INFORMATION

COURSE NAME TENTH ANNUAL REVIEW COURSE IN CLINICAL OBSTETRICS & GYNECOLOGY/HISTOPATHOLOGY

DATES November 16 - 21, 1987

CONTACT HOURS 44.5-AMA 34.0-CMA COURSE NUMBER 1712/70

*Philip J. Quiaia M.D.*

INSTRUCTOR OR PROVIDER SIGNATURE

EDITOR-IN-CHIEF  
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COEDITORS  
Roger D. Kempers, M.D.  
Ronald J. Bolognese, M.D.  
EDITORIAL ASSISTANT  
Carol Olson  
CIRCULATION MANAGER  
Diane Kitko

# POSTGRADUATE OBSTETRICS & GYNECOLOGY


EDITORIAL BOARD  
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John T. Queenan, M.D.  
Richard H. Schwarz, M.D.  
Leon Speroff, M.D.

P.O. BOX 23263, BALTIMORE, MARYLAND 21203

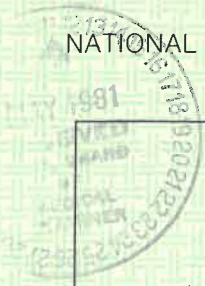
(301) 955-7822

As an organization for continuing medical education, the University of Pennsylvania School of Medicine designates Postgraduate Obstetrics and Gynecology as meeting the criteria for 1 credit hour per biweekly issue in Category 1 for Education Materials for the Physician's Recognition Award of the American Medical Association provided it has been completed according to instructions.

This is to certify that you have successfully completed 26 tests, lessons 1-26, inclusive, in Postgraduate Obstetrics and Gynecology in Volume 7, 1987. You have earned 1 hour, AMA Category I; 1 hour, AOA Category 2B; and/or 1 ACOG Formal Learning Cognate for each lesson.

Jan Whitefield, M.D. 1735  


ENDORSEMENT OF CERTIFICATION



NATIONAL BOARD OF MEDICAL EXAMINERS  
OF THE  
UNITED STATES OF AMERICA

**Jan Eugene Whitefield, M.D.**

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest: **WILLIAM B. HOLDEN**  
Chairman of the Board

SEAL

**EDITHE J. LEVIT**  
President of the Board

Philadelphia, Pa.

**07/01/81**

Cert. # **226248**

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of **U OF NEW MEXICO SCH MED** in **MAY 1980**, whose birth date is **██████/1945**, following successful completion of all examinations required for Certification by the National Board of Medical Examiners.

The grades obtained are as follows:

	Standard* Score	Scale Score
<b>PART I passed <u>06/78</u></b>		
Anatomy, incl. histology and embryology .....	535	83
Physiology .....	575	85
Biochemistry .....	475	79
Pathology .....	415	75
Microbiology, incl. immunology .....	465	78
Pharmacology and Materia Medica .....	460	78
Behavioral Sciences .....	565	85
<u>(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**</u>	495	80
<b>Part II passed <u>09/79</u></b>		
Internal medicine and the medical specialties .....	470	81
Surgery and the surgical specialties .....	430	79
Obstetrics and Gynecology .....	560	85
Public Health and Preventive Medicine .....	510	83
Pediatrics .....	505	82
Psychiatry .....	415	78
<u>(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**</u>	480	81
<b>PART III passed <u>03/81</u></b>		
A General Test of Clinical Competence .....		
<u>(Minimum Passing Grade 290/75)</u> AVERAGE	480	81.4
<u>GENERAL AVERAGE (Parts I, II, and III)</u> .....		80.8
		(Scale Score)

\*Examinations taken since June 1971 are reported with both Standard and Scale Score Equivalents.

\*\*Since 1966 National Board criteria for certification are based upon candidate's Total Grade in Part I, Part II, and Part III, and not scores of individual subjects within each Part.

*Ann K. Severling*  
Secretary for Certification  
05/05/81

SEAL

Date

State Of New Mexico

Board Of Medical Examiners



TONY ANAYA GOVERNOR
KENT F. JACOBS, M.D. PRESIDENT
THEODORE E. HAUSER, M.D. VICE-PRESIDENT
JAMES W. MAYER, M.D. SECRETARY-TREASURER

CORTEZ WILLIAMS, PH.D. MEMBER
GEORGE P. BUNCH, M.D. MEMBER
EUGENE CASTIGLIA, M.D. MEMBER

Michelle McGinnis, - Administrator
227 EAST PALACE AVENUE - SUITE 0
SANTA FE, NM 87501
(505) 827-9930

February 27, 1985

Jan Eugene Whitefield, M.D.



Dear Dr. Whitefield:

I am happy to inform you that you passed Day 3 of the Federation Licensing Examination taken on December 6, 1984. Enclosed is a copy of your scores.

Sincerely,

NEW MEXICO BOARD OF MEDICAL EXAMINERS

Handwritten signature of Michelle McGinnis

Michelle McGinnis
Administrator

MM:edm

Enclosure

Table with columns: NAME, ST. NO., NC. NO., EXAM SUBJECTS (ANAT, PHYS, SIC, PATH, MICRO, PHAR, JLF, S, MED, SURG, EB, PH, PED, PSY), and WEIGHTED AVG. Includes rows for JAN E and CLIN SCI.



State Of New Mexico

# Board Of Medical Examiners



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EUGENE CASTIGLIA, M.D.  
MEMBER

Michelle McGinnis, - Administrator  
227 EAST PALACE AVENUE - SUITE 0  
SANTA FE, NM 87501  
(505) 827-9930

February 7, 1985

Jan Eugene Whitefield, M.D.

Dear Dr. Whitefield:

I am happy to inform you that you passed Day 3 of the Federation Licensing Examination taken on December 6, 1984. Enclosed is a copy of your scores.

Sincerely,

NEW MEXICO BOARD OF MEDICAL EXAMINERS

*Michelle McGinnis*

Michelle McGinnis  
Administrator

MM:edm

Enclosure

State Of New Mexico

# Board Of Medical Examiners



**TONY ANAYA**  
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**EUGENE CASTIGLIA, M.D.**  
MEMBER

Michelle McGinnis, - Administrator  
227 EAST PALACE AVENUE - SUITE 0  
SANTA FE, NM 87501  
(505) 827-9930

November 27, 1984

Jan Eugene Whitefield, M. D.

Dear Doctor Whitefield:

The Federation Licensing Examination will be administered in the Onate Room of the Hilton Inn, located on the corner of San Francisco Street and Sandoval Street. I am enclosing a city map to guide you.

Please report at 8:00 A.M. on December 6th and bring two #2 lead pencils with you.

Sincerely,

Michelle McGinnis  
Administrator

MM:gm

Enclosure

November 16, 1984

Jan Eugene Whitefield, M.D. *APR 95*

[REDACTED]

Dear Doctor Whitefield:

The Federation Licensng Examination will be administered in the Onate Room of the Hilton Inn, located on the corner of San Francisco Street and Sandoval Street. I am enclosing a city map to guide you.

Please report at 8:00 A.M. on December 4th and bring two #2 lead pencils with you.

Sincerely,

Michelle McGinnis,  
Administrator

MM:blg

Enclosure

# FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. FLEX APPLICATION

## PART A — To Be Completed By Applicant.

Print all information. Complete all 12 items and return this form to the state medical board for which you are taking FLEX.

<b>1. NAME</b>	W H I T E F I E L D <small>Last (Surname)</small>		
	J A N E <small>First and Middle Name or Initial</small>		
	ALTERNATE SURNAME: To be filled out only by individuals who used another name for FLEX previously.		
<b>2. DATE OF BIRTH</b>	[Redacted] [Redacted] [Redacted] <small>Day Month Year</small>	<b>3. CITIZENSHIP AT BIRTH</b>	<input checked="" type="checkbox"/> U.S.A. <input type="checkbox"/> Canada <input type="checkbox"/> Other (Specify) <u>081 USA</u> <small>*Refer to Country Code List on back.   *Country Code   Name of Country</small>
<b>4. SOCIAL SECURITY NUMBER</b>	Used to assure identification [Redacted]		<b>5. SEX</b>
			<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
<b>6. HAVE YOU PREVIOUSLY TAKEN FLEX?</b>	<input type="checkbox"/> YES   If Yes: a) When was the most recent FLEX taken? [ ] [ ] 1 9 [ ] [ ] <small>Month Year</small> <input checked="" type="checkbox"/> NO   b) How many previous FLEX examinations have you taken? _____		
<b>7. CITIZENSHIP UPON ENTERING MEDICAL SCHOOL</b>	<input checked="" type="checkbox"/> U.S.A. <input type="checkbox"/> Canada <input type="checkbox"/> Other (Specify) <u>081 USA</u> <small>*Refer to Country Code List on back.   *Country Code   Name of Country</small>		
<b>8. MEDICAL EDUCATION</b>	a) <u>UNIV OF New Mexico</u> <small>Name of Medical School of Graduation</small> b) Country of Medical School: <input checked="" type="checkbox"/> U.S.A. <input type="checkbox"/> Canada <input type="checkbox"/> Other (Specify) <u>081 USA</u> <small>*Country Code   Name of Country</small> c) Graduation Year: <u>1 9 8 0</u> <small>*Refer to Country Code List on back.</small> d) Degree: <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Other (Specify) _____		
<b>9. OTHER EXAMINATIONS TAKEN</b>	Examination <input type="checkbox"/> ECFMG <input type="checkbox"/> VQE <input checked="" type="checkbox"/> NBME <input type="checkbox"/> None of the Above	Most Recent Date Taken (Month, Year) <u>03/1981</u> _____ /19 _____ /19	Identification Number ECFMG [ ] [ ] [ ] [ ] [ ] [ ] VQE [ ] [ ] [ ] [ ] [ ] [ ] NBME <u>2 2 6 2 9 8</u>
<b>10. FEDERATION IDENTIFICATION NUMBER (FIN) IF KNOWN</b>	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]		<b>11. DATE OF THIS APPLICATION</b>
			[ ] [ ] 0 7 0 7 [ ] [ ] [ ] [ ] [ ] [ ] <small>Day Month Year</small>
<b>12. APPLICATION STATEMENT &amp; SIGNATURE</b>	I certify that the information supplied in this application is true and accurate to the best of my knowledge. SIGNATURE <u>Jane E Whitefield MD</u>		

## PART B — To Be Completed By State Board

<b>1. STATE FOR WHICH FLEX IS BEING TAKEN</b>	<u>New Mexico</u> <small>Name of State</small>	<u>1 3 2</u> <small>State Code No.</small>	<b>2. APPLICANT'S STATE BOARD ID NUMBER</b>	<u>N M 0 1 6</u>
<b>3. PLACE &amp; DATE OF EXAMINATION</b>	<u>New Mexico</u> <small>Test Center State</small>	<u>1 3 2</u> <small>Center State Code No.</small>	<input type="checkbox"/> June 19 _____ <input checked="" type="checkbox"/> December 19 <u>84</u>	
<b>4. EXAMINATION(S) FOR WHICH REGISTERED</b>	<input type="checkbox"/> Complete FLEX <input type="checkbox"/> Basic Science <input type="checkbox"/> Clinical Science <input checked="" type="checkbox"/> Clinical Competence <input type="checkbox"/> Other _____ <small>(Specify)</small>			

State Of New Mexico

# Board Of Medical Examiners



**TONY ANAYA**  
GOVERNOR

**KENT F. JACOBS, M.D.**  
PRESIDENT

**THEODORE E. HAUSER, M.D.**  
VICE-PRESIDENT

**JAMES W. MAYER, M.D.**  
SECRETARY-TREASURER

**CORTEZ WILLIAMS, PH.D.**  
MEMBER

**GEORGE P. BUNCH, M.D.**  
MEMBER

**EUGENE CASTIGLIA, M.D.**  
MEMBER

Michelle McGinnis, - Administrator  
227 EAST PALACE AVENUE - SUITE 0  
SANTA FE, NM 87501  
(505) 827-9930

September 6, 1984

Ms. Glenda Fairchild  
Texas Board of Medical Examiners  
Post Office Box 13562, Capitol Station  
Austin, TX 78711

RE: Jan Eugene Whitefield, M. D.

Dear Ms. Fairchild:

This is to verify that the above named physician has applied and been accepted for Day III of FLEX to be given December 1984 in New Mexico. If further documentation is required please advise.

Sincerely,

NEW MEXICO BOARD OF MEDICAL EXAMINERS  
Michelle McGinnis, Administrator

By: (Mrs.) Sylvia R. Gallegos  
License Coordinator

MM:sg

cc: Jan Eugene Whitefield, M. D.  
419 Monroe NE #9E  
Albuquerque, NM 87108

KENT F. JACOBS, M.D.  
PRESIDENT  
THEODORE E. HAUSER, M.D.  
VICE-PRESIDENT



CORTEZ WILLIAMS, PH.D.  
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MEMBER

*New Mexico Board of Medical Examiners*

JAMES W. MAYER, M.D., SECRETARY-TREASURER

227 EAST PALACE AVENUE - SUITE 0  
SANTA FE, NEW MEXICO 87501  
(505) 827-9930

July 13, 1984

Jan Whitefield, M. D.

Dear Doctor Whitefield:

The fee for taking Day III of FLEX in December is \$130 payable by cashier's check or money order. This fee must be received by September 24th. Please complete the enclosed FLEX Application and return along with the required fee.

As requested in your letter of June 28th I enclose a notarized copy of your National Board scores.

Sincerely,

Michelle McGinnis, Administrator  
NEW MEXICO BOARD OF MEDICAL EXAMINERS

By: (Mrs.) Sylvia R. Gallegos  
License Coordinator

MM:sg

Enclosure

7/6/84

\$130

6/28/84

To: New Mexico Board of Medical Examiners

From: JAN WHITEFIELD, MD

Dear Sirs:

I am attempting to obtain licensure in Texas by reciprocity. I need three things from your office to accomplish this.

① Endorsement of my state application to Texas, item #12, that I was licensed in New Mexico, including the date of licensing. According to their instructions, the following must appear on the endorsement: Signature of the secretary or chief Executive officer, Seal of the licensing agency, and date of endorsement.

\* ② Notarized copy of the National Board Scores

③ Also, I would like to request the opportunity to sit in for FLEX day III here in New Mexico in Dec., 1984. This exam is required for reciprocal licensing. I understand a courtesy Day III exam is offered here.

Please complete item #12 on the application, and forward it to me at your earliest possible convenience. I would be happy to pay any necessary fees to do the above.

Return the application to the address below

Thank you -

JAN WHITEFIELD, MD



RELEASE OF INFORMATION

I, JAN Eugene WINTERFELD, have applied to the New Mexico Physicians Mutual Liability Company for medical malpractice insurance. In exchange for the agreement, I hereby authorize any and all medical schools, hospitals, physicians, clinics, insurance companies, governmental agencies, state medical societies, county medical societies and licensing authorities to disclose to New Mexico Physicians Mutual Liability Company or its representatives any and all information concerning my medical training, practice, and any other matters which might be of significance for the insurance underwriting purposes; and I expressly release and discharge all such informants, New Mexico Physicians Mutual Liability Company and their agents from any liability of any kind whatever in any manner arising from such disclosure of information.

I further state that I authorize a photocopy of this authorization to be accepted with the same authority as the original.

JAN Eugene Winterfeld  
Signature

2/22/82  
Date

6-30-45

PA

81-241

11-16-81

X

X



WHITEFIELD



AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION  
535 NORTH DEARBORN STREET  
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES  
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 07-14-81  
TIME: 1:09 PM

NAME: WHITEFIELD, JAN EUGENE, M.D.  
ADDRESS: 916 SOLANO DR NE ALBUQUERQUE NM 87110  
BIRTHPLACE: ROCHESTER, PA BIRTHDATE: [REDACTED]/45  
MEDICAL EDUCATION (SCHOOL YEAR):  
UNIV OF NEW MEXICO SCH MED, ALBUQUERQUE NM 87131 1980  
NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE  
LICENSES:

NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES:  
RESIDENT

PRIMARY SPECIALTY: FAMILY PRACTICE  
SECONDARY SPECIALTY: UNSPECIFIED  
TERTIARY SPECIALTY: UNSPECIFIED  
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE  
MEMBER OF AMA: NOT MEMBER

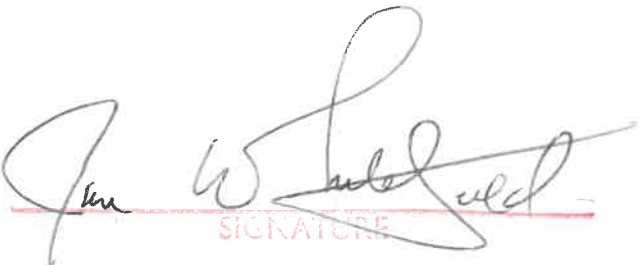
NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE  
PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

CURRENT MEDICAL TRAINING: INTERN  
HOSPITAL: BERNALILLO CO MED CENTER ALBUQUERQUE NM 87106  
DATES OF TRAINING: 07/80-06/81  
SPECIALTY: FAMILY PRACTICE  
SPECIALTY: UNSPECIFIED

INTERNSHIP:  
NONE REPORTED TO DATE

RESIDENCY:  
NONE REPORTED TO DATE

COPYRIGHT 1981 AMERICAN MEDICAL ASSOCIATION \*\*AMA FILES CHECKED\*\* SEE REVERSE

  
SIGNATURE

May 12, 1981

Jan Eugene Whitefield, M. D.



Dear Doctor Whitefield:

This is to acknowledge receipt of your application for medical licensure in the State of New Mexico through endorsement of National Board along with a copy of your medical diploma, fingerprint chart, photograph, two letters of recommendation, copy of your military discharge and \$100 fee. I enclose your receipt.

If you need a temporary license valid until the next regular meeting of the Board in November 1981 it will be necessary for you to have a personal interview with me. For an appointment please call my secretary at (505) 827-2215.

Sincerely,

R. C. Derbyshire, M. D.  
Secretary-Treasurer

RCD:sg

Enclosure: Receipt #6074

# The University of New Mexico

has conferred upon

**Sam Eugene Whitefield**

the degree of

**Doctor of Medicine**

with all the rights and privileges appertaining to that degree.

in testimony whereof the Regents of the University upon recommendation of the Faculty have granted this diploma bearing the seal of the University

this eighteenth day of May, nineteen hundred and eighty-

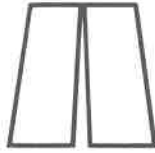
*Samuel P. Davis*  
President of the Regents

*Robert P. Ross*  
Secretary of the Regents

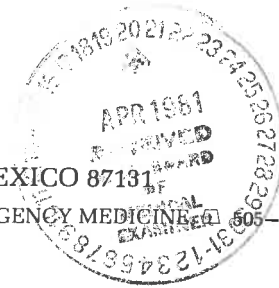


*William E. Davis*  
President of the University

*Emma Johnson*  
Secretary of the University  
*Dorothy H. H. H.*  
Dean of the School



THE UNIVERSITY OF NEW MEXICO □ ALBUQUERQUE, NEW MEXICO 87131  
SCHOOL OF MEDICINE □ DEPARTMENT OF FAMILY, COMMUNITY, AND EMERGENCY MEDICINE □ 505-277-2165  
DIVISION OF FAMILY MEDICINE □ 620 CAMINO DE SALUD N.E.



April 17, 1981

R.C. Derbyshire, M.D.  
Secretary-Treasurer  
New Mexico Board of  
Medical Examiners  
227 East Palace Place  
Suite 0  
Santa Fe, NM 87501

re: Jan Whitefield, M.D.

Dear Dr. Derbyshire:

Dr. Whitefield joined our residency in late June of 1980 as a first year resident. I have known Dr. Whitefield from his medical school days as well as during his internship.

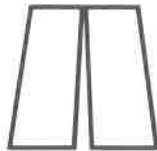
Dr. Whitefield is a bright, concerned, and appropriate physician with high ethical standards. He will make an excellent physician for the state of New Mexico.

I have no hesitation in recommending him to you very highly.

Sincerely,

Berthold E. Umland, M.D.  
Assistant Professor  
Medical Director  
Family Practice Center

BEU:jsh



THE UNIVERSITY OF NEW MEXICO □ ALBUQUERQUE, NEW MEXICO 87131  
SCHOOL OF MEDICINE □ DEPARTMENT OF FAMILY, COMMUNITY, AND EMERGENCY MEDICINE □ 505-277-2165  
DIVISION OF FAMILY MEDICINE □ 620 CAMINO DE SALUD N.E.

April 17, 1981

R.C. Derbyshire, M.D.  
Secretary-Treasurer  
New Mexico Board of  
Medical Examiners  
227 East Palace Place  
Suite 0  
Santa Fe, NM 87501

re: Jan Whitefield, M.D.

Dear Dr. Derbyshire:

This is a letter of support for Jan Whitefield, M.D., who has an application pending before the Board for licensure in New Mexico.

Dr. Whitefield is a 1980 graduate of the University of New Mexico School of Medicine and came to us highly recommended. He is presently in the last half of his first year of his family practice residency. He has performed his duties in a fine fashion and has received good, solid evaluations on all his rotations.

Dr. Whitefield is a very bright physician with high ethical standards and it is a pleasure to recommend him to you without reservation.

Sincerely,

Warren A. Heffron, M.D.  
Associate Professor  
Director, Family Medicine

WAH:jsh



NOV 04 Rec'd

833302

NEW MEXICO BOARD OF MEDICAL EXAMINERS  
P.O. Box 20001/491 Old Santa Fe Trail  
Santa Fe, New Mexico 87503  
(505)827-7317

==>1989 REGISTRATION



Amount Rec. \_\_\_\_\_  
Processed By SM  
Returned \_\_\_\_\_  
Date Mailed \_\_\_\_\_

ANNUAL REGISTRATION OF YOUR PHYSICIANS LICENSE IS NOW DUE. PLEASE RETURN AND COMPLETE THE INFORMATION BELOW.  
RETURN THIS FORM AND "\$60.00" BY DECEMBER 31, 1988. THE 1989 ROSTER WILL ONLY INCLUDE NAMES FROM REGISTRATIONS  
RECEIVED COMPLETE, CORRECT, AND RETURNED BEFORE THE DEADLINE.

LICENSE #: 81-341

NAME : JAN E WHITEFIELD M.D.

ADDRESS : 2740 LAKE OTIS PARKWAY

ADDRESS :

CITY/ST/ZIP: ANCHORAGE, AK 99508

PHONE: 907-258-6162 BIRTH DATE: [REDACTED] 45 / / SSN: [REDACTED] / /

HOME ADDRESS

ADDRESS :

ADDRESS :

CITY/ST/ZIP: ANCHORAGE, AK 99504

PHONE: 907-337-7079

EXAM: NATIONAL BOARD

SCHOOL : UNIV OF NEW MEXICO

HOSPITAL: ADD ANY HOSPITALS WHERE YOU HAVE BEEN GIVEN PRIVILEGES IN 1988 IF NOT LISTED.

PROVIDENCE HOSP

HUMANA HOSP

INSTRUCTIONS

The Medical Board's current records contain the above information. Please check all information for accuracy. Information that is incorrect or has changed since you registered last year, should be corrected in the space provided at the right. Also please add any new hospital affiliations you may have acquired since January of 1988. IF YOUR BUSINESS ADDRESS HAS CHANGED, YOU SHOULD REMEMBER THAT YOU MUST FURNISH THE BOARD WITH A LOCATION ADDRESS. A POST OFFICE BOX IS NOT ACCEPTABLE. Information requested below is new information or reverification information that must be received yearly. All blanks below must contain a response before your form will be processed. ALL REGISTRATION FORMS RECEIVED INCOMPLETE, UNSIGNED OR WITHOUT \$60.00 "WILL NOT" BE PROCESSED UNTIL ALL ITEMS ARE COMPLETE. DELAY WILL MEAN THAT YOUR NAME WILL NOT BE PRINTED IN THE 1989 ROSTER. CHECKS RECEIVED WITH INCOMPLETE FORMS WILL BE DEPOSITED WITH THE STATE TREASURER'S OFFICE IN ACCORDANCE WITH STATE LAW. NO FEE WILL BE RETURNED.

ANSWER QUESTIONS BELOW

During 1988 have you been convicted of a felony or had action against any M.D. license you hold? YES  NO  
If you answered YES to the above question an explanation must be attached.

ARE YOU A U.S. GRAD? YES  NO  ECFMG #: \_\_\_\_\_ DEA #: AW 1406417

STATE LICENSES EVER HELD:

ST: NM LIC #: 81-341

ST: AK LIC #: AA-3068

ST: TX LIC #: G8770

ST: \_\_\_\_\_ LIC #: \_\_\_\_\_

ST: \_\_\_\_\_ LIC #: \_\_\_\_\_

ACTIVE STATUS

I wish my license to remain active K. I have enclosed my check for \$60.00 K.

\*INACTIVE STATUS

I WISH MY LICENSE TO BECOME INACTIVE AT THIS TIME \_\_\_\_\_.

With an inactive license I understand that, in accordance with New Mexico law, I may not practice in any form including the writing of prescriptions \_\_\_\_\_.

\*New Mexico law only provides for an active or inactive status.

All those wishing to practice even in a limited capacity must have a full license and stay current in reporting CME'S.

I verify that all above information is true and accurate on this date.

Date: 4/4/89

SIGNATURE: Jan Whitefield

(must be signed by physician)

NOTE: IF YOU HAVE RECEIVED A CME REPORT FORM, BOTH THIS AND THE CME REPORT MUST BE RETURNED TOGETHER.

112001

RECEIVED

21000  
RB

APR 30 1991

NEW MEXICO BME, P O BOX 20001, SANTA FE, NEW MEXICO 87504

SECTION C

JULY 1, 1991 - JUNE 30, 1992 TRIENNIAL RENEWAL

SECTION C

NM BOARD OF  
MEDICAL EXAMINERS

PLEASE REVIEW INFORMATION PROVIDED, ANSWER ALL QUESTIONS AND MAKE CORRECTIONS IN THE SPACE PROVIDED.

FEES - CHECK ENCLOSED \$ 210 FEES ARE NON-REFUNDABLE NMSA 61-6-19.

ACTIVE STATUS \$210.00  I WISH MY LICENSE TO REMAIN ACTIVE.

\*INACTIVE STATUS \$ 25.00  I WISH MY LICENSE TO BECOME INACTIVE.

WITH AN INACTIVE LICENSE I UNDERSTAND THAT, IN ACCORDANCE WITH NEW MEXICO LAW, I MAY NOT PRACTICE MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS.

LICENSE #: 81-341 DEA #: [REDACTED] SSN: [REDACTED] BIRTH DATE: [REDACTED]/45

NAME : JAN E WHITEFIELD M.D.

BUS-ADDR : 2740 LAKE OTIS PARKWAY

BUS-ADDR :

CITY/ST/ZIP: ANCHORAGE, AK 99508

BUS-PHONE : 907-258-6162

OUT-OF-STATE RESIDENTS PRACTICING IN NEW MEXICO, PLEASE PROVIDE NEW MEXICO BUSINESS ADDRESS:

HOME-ADDR : [REDACTED]

HOME-ADDR :

CITY/ST/ZIP: ANCHORAGE, AK 99504

HOME-PHONE : [REDACTED]

YOU ARE RESPONSIBLE FOR NOTIFYING THE BOARD OF ANY ADDRESS CHANGE. NMSA 61-6-28.

HOSPITAL PRIVILEGES: NEW HOSPITAL PRIVILEGES SINCE LAST RENEWAL:

PROVIDENCE HOSP

HUMANA HOSP

OTHER STATE LICENSES:

ST: AK LIC#: AA3068 ST: TX LIC#: G8770 ST: LIC#:

ST: LIC#: ST: LIC#: OTHER STATE LIC: \_\_\_\_\_

SPECIALITY (1) OBG ARE YOU BOARD CERTIFIED  YES  NO

SPECIALITY (2) ARE YOU BOARD CERTIFIED  YES  NO

LIST ALL PA'S AND/OR NURSE PRACTITIONERS THAT ARE CURRENTLY UNDER YOUR SUPERVISION:

Colleen Merkal Teresa Jenkins  
Susan Lane PA

Are you known by any other name(s)? No (Specify)

Have you ever been convicted of a misdemeanor or felony?  NO  YES

Has any licensing authority, professional organization, medical institution or other medically related entity ever instituted disciplinary action or proceedings against you  NO  YES

Have you ever surrendered your license privileges or membership to any licensing authority, professional organization, medical institute or other medically related entity?  NO  YES

- IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, ATTACH DETAILED EXPLANATION AND DOCUMENTATION.

I verify that all above information is true and accurate.

SIGNATURE: Jan Whitefield DATE: 4/22/91

(Must be signed by physician)



NEW MEXICO BME, P O BOX 20001, SANTA FE, NEW MEXICO 87504  
NEW MEXICO BOARD OF MEDICAL EXAMINERS VERIFICATION OF CONTINUING EDUCATION  
(61-6-21 / 61-6-26 NMSA 1978 AND NMBME RULE 5)

MUST BE RETURNED WITH RENEWAL FORM

DOCUMENTATION MUST BE ATTACHED (CERTIFICATE OF ATTENDANCE, ETC.)

NAME: JAN E WHITEFIELD M.D. LICENSE NUMBER: 81-341

I certify that I have completed the Continuing Medical Education requirement for renewal of my license in 1991 during the calendar years 1988, 1989, 1990: (January 1, to December 31)

AMA Category I Accredited		
- Clinical Courses.	Year _____	Credit Hours <u>164</u>
- AMA Physicians Recognition Award	Year _____	Credit Hours _____
- AAFP Certificate of CME	Year _____	Credit Hours _____
- Certification or Recognition by ABMS Speciality Board	Year _____	Credit Hours _____
- FLEX Component II	Year _____	Credit Hours _____
- Internship, Residency or Fellowship (40 hours maximum per year)		Credit Hours _____
- Advanced Degree In Medically Related Field (40 hours maximum per each full year of study)		Credit Hours _____
- Self Assessment Tests: (No Limit)		Credit Hours <u>26</u>
- Teaching (40 hours maximum)		Credit Hours <u>40</u>
- Preceptors: (30 hours maximum)		Credit Hours _____
- Scientific Paper or Publications (original) (30 hours maximum)		Credit Hours _____
		Total Credit Hours <u>230</u>

Date

4/22/91

Signature

Jan Whitefield

(NOT VALID UNLESS SIGNED AND DATED BY PHYSICIAN)

STAFF USE ONLY:

CMES Approved By

D. Welby

Date: 5/6/91

Doc. Rec.

JAN WHITEFIELD



ACOG Cognate Program  
409 12th Street, SW  
Washington, DC 20024-2188

has attended,

ACOG # 0270924

ACOG ANNUAL MEETING  
GENERAL SESSION  
MAY 7 THRU 10 1990  
SAN FRANCISCO CA  
17 COGNATES 17 HRS AMA I

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNCOLOGISTS

Non-Fellows retain both copies

FELLOW/JUNIOR FELLOW COPY

0290924

Jan Whitefield, MD

ACOG Cognate Program  
409 12th Street, SW  
Washington, DC 20024-2188

has attended.

ACOG ANNUAL MEETING  
120 POSTGRADUATE COURSE  
MAY 5 THRU 6 1990  
SAN FRANCISCO CA  
12 COGNATES 12 HRS AMA I

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNCOLOGISTS

Non-Fellows retain both copies

FELLOW/JUNIOR FELLOW COPY

JAN WHITEFIELD



ACOG Cognate Program  
409 12th Street, SW  
Washington, DC 20024-2188

has attended,

ACOG # 0270924

ACOG ANNUAL MEETING  
660 POSTGRADUATE COURSE  
MAY 8 THRU 10 1990  
SAN FRANCISCO CA  
6 COGNATES 6 HRS AMA I

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNCOLOGISTS

Non-Fellows retain both copies

FELLOW/JUNIOR FELLOW COPY

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

PROGRAM FOR CONTINUING PROFESSIONAL DEVELOPMENT



ACOG COGNATE PROGRAM

409 12th Street, S.W.  
Washington, D.C. 20024-2188  
(800) 673-8444 • (202) 863-2402

TRANSCRIPT

ACOG ID NUMBER **CB-0270924**

PAGE NO.  
**1**

**JAN E. WHITEFIELD M.D.**



**AK 99504-4547**

COGNATES REPORTED THROUGH MAR 15 1990

DATE OF ISSUE **04/11/90**

TOTAL AWARD COGNATES

FINDER # (ACOG USE ONLY)	ACTIVITY DATE	CODE	CME ACTIVITY	CYCLE	CREDITED COGNATES	ADDITIONAL COGNATES	TOTAL AWARD COGNATES		
							CAT I	CAT II	CAT III
871103-000	03/24/87	32	PRESENTATION AT SCIENTIFIC MTG	14	5	0	0	0	5
871103-002	09/20/87	01	POSTGRAD COURSE/SPECIALTY MEET	14	12	0	12	0	5
871207-001	11/17/87	01	POSTGRAD COURSE/SPECIALTY MEET	14	17	0	29	0	5
871207-000	11/21/87	01	POSTGRAD COURSE/SPECIALTY MEET	14	26	0	55	0	5
871229-000	12/31/87	11	OTHER SELF-INSTRUCTION PROGRAMS	14	26	0	81	0	5
880606-001	06/03/88	03	PROLOG	14	25	0	106	0	5
880606-000	06/03/88	03	PROLOG	14	25	0	131	0	5
880714-000	07/11/88	03	PROLOG	14	25	0	156	0	5
890608-001	12/01/88	13	INTERACTIONS	14	3	0	159	0	5
890608-002	12/02/88	13	INTERACTIONS	14	3	0	162	0	5
890608-003	12/03/88	13	INTERACTIONS	14	3	0	165	0	5
890106-000	12/29/88	03	PROLOG	14	25	0	190	0	5
890608-000	12/30/88	13	INTERACTIONS	14	3	0	193	0	5
890607-000	01/31/89	13	INTERACTIONS	14	3	0	196	0	5
890607-001	03/14/89	13	INTERACTIONS	14	3	0	199	0	5
890717-001	07/04/89	13	INTERACTIONS	14	3	0	202	0	5
890717-002	07/05/89	13	INTERACTIONS	14	3	0	205	0	5
890717-000	07/06/89	13	INTERACTIONS	14	3	0	208	0	5
891218-000	12/11/89	11	OTHER SELF-INSTRUCTION PROGRAMS	14	26	0	234	0	5

SUMMARY OF COGNATES FOR PRIMARY CYCLE					14	AWARD REC'D
REPORTING YEARS	CAT. I	CAT. II	CAT. III	TOTAL		
87	81	0	5	86		
88	112	0	0	112		
89	41	0	0	41		
<b>TOTAL COGNATES THIS CYCLE</b>						<b>239</b>

SUMMARY OF COGNATES FOR SECONDARY CYCLE					17	
REPORTING YEARS	CAT. I	CAT. II	CAT. III	TOTAL		
90	0	0	0	0		
91	0	0	0	0		
92	0	0	0	0		
<b>TOTAL COGNATES THIS CYCLE</b>						<b>0</b>



414700

SECTION C

BOARD OF MEDICAL EXAMINERS

491 Old Santa Fe Trail
Second Floor, Lamy Building
Santa Fe, New Mexico 87501

Administration (505) 827-5022
Financial (505) 827-6759

TRIENNIAL LICENSE RENEWAL
JULY 1, 1994 - JUNE 30, 1997

Applications (505) 827-9933
Verifications (505) 827-7317

RENEWALS DUE ON OR BEFORE JULY 1, 1994. §61-6-16 (A)-(F) NMSA 1978.
There are substantial penalties for late renewals. §61-6-19 NMSA 1978.

JAN E WHITEFIELD, M.D.
4115 LAKE OTIS PARKWAY

RECEIVED

ADDRESS CORRECTION REQUESTED

ANCHORAGE AK 99508-5213

MAY 27 1994

Business phone

NM BOARD OF
MEDICAL EXAMINERS

Out of state physicians - provide New Mexico business address, if any.

NM Bus Addr: \_\_\_\_\_ City/St/Zip \_\_\_\_\_

FEEs: Active Status \$210.00 Inactive Status 25.00
(A licensee on inactive status may not practice medicine nor write prescriptions.)
It is the licensee's responsibility to notify the Board of changes in address of either business or home. §61-6-18 NMSA 1978.
Please review the information below for accuracy.

License # Social Security # DEA # Date of Birth
81-341 [redacted] [redacted] 1945

Home Address: [redacted]

Other State Licenses:
State AK # AA3068 State TX # G8770 State #
State # State # State #

ABMS Specialty (1) OBSTETRICS AND GYNECOLOGY Board certified? No YES
ABMS Specialty (2) Board certified?

Physician Assistants/Nurse Practitioners under your supervision:
PA's -
NP's - TERESA JENKINS Colleen Markkal, Barbara Norton

Hospital Privileges:
1) PROVIDENCE HOSP
2) HUMANA HOSP
3) KODIAK ISLAND Hospital
4)
Additional Hospital Privileges:

If you answer yes to any of the following questions and have not previously disclosed the information to the Board, please provide an explanation of the events.

Are you at the present time known by any other name? If so, what name? N/A

Have you ever used or ever been licensed under another name(s)? If so, what name(s)? No N/A

Have you been denied a certificate after taking an examination or denied the privilege of taking an examination by a medical licensing board? Yes  No

Has a medical licensing board started disciplinary action against your license? Yes  No

Have you been charged with violation of a federal, state or local statute (except minor traffic citations)? Yes  No

Have you had disciplinary action started against you by a hospital staff, a state or county medical society, HMO, PPO, IPA or PRO? Yes  No

Have you had a malpractice settlement or judgment against you? <sup>never</sup> Yes  No

Do you have any malpractice or medically related claims or lawsuits pending against you? <sup>gw</sup> Yes  No

Have you had personal or legal problems with narcotics, alcohol or other dangerous drugs? Yes  No

I verify that all the above information is true and accurate.

SIGNATURE *Jan Whitefield*  
(must be signed by licensee)

Date 5/17/94

CME Certification Form Attached

NM BOARD OF MEDICAL EXAMINERS

LAMY BUILDING, SECOND FLOOR
491 OLD SANTA FE TRAIL
SANTA FE, NEW MEXICO 87501

Administration (505) 827-5022

Verifications (505) 827-7317

AS A CONDITION OF LICENSE RENEWAL, ALL LICENSED PHYSICIANS MUST REPORT AND DOCUMENT 75 HOURS OF CONTINUING MEDICAL EDUCATION ONCE EVERY THREE YEARS. REPORTING YEARS - JANUARY 1, 1991 THROUGH DECEMBER 31, 1993. (RENEWALS AND CME'S DUE ON OR BEFORE JULY 1, 1994)

NAME: \_\_\_\_\_ M.D. LICENSE #: \_\_\_\_\_

DOCUMENTATION MUST BE ATTACHED

I certify that I have complied with the Continuing Medical Education requirement for renewal of my license and that appropriate documentation is attached.

- A M A Category I Accredited
- Clinical Courses. Year \_\_\_\_\_ Credit Hours 123
- A M A Physicians Recognition Award Year 1993 error
- A A F P Certificate of CME Year \_\_\_\_\_ See enclosed schedule.
- Certification or Recertification by ABMS Specialty Board Year \_\_\_\_\_
- FLEX Component II Year \_\_\_\_\_
- Internship, Residency or Fellowship Inclusive dates \_\_\_\_\_
- Advanced Degree In Medically Related Field Year(s) \_\_\_\_\_
(40 hours maximum per each full year of study) Credit Hours \_\_\_\_\_
- Self Assessment Tests: Certificate of credit must be attached (No limit) Credit Hours \_\_\_\_\_
- Teaching Statement from approved medical school must be attached (40 hours maximum) Credit Hours \_\_\_\_\_
- Preceptors: Statement from approved medical school must be attached (30 hours maximum) Credit Hours \_\_\_\_\_
- Scientific Paper or Publications (original) 10 hours per paper copy(ies) must be attached (30 hours maximum) Credit Hours \_\_\_\_\_

Date 5/19/94

Signature (NOT VALID UNLESS SIGNED BY PHYSICIAN)

STAFF USE ONLY: CMEs Approved By \_\_\_\_\_

Date: 6/10/94 Doc. Rec. [check]

# THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

## PROGRAM FOR CONTINUING PROFESSIONAL DEVELOPMENT

### ACOG COGNATE PROGRAM

409 12th Street, S.W.  
Washington, D.C. 20024-2188  
(800) 673-8444 • (202) 863-2402

# TRANSCRIPT



ACOG ID NUMBER

F 0270924

PAGE NO.

1

Jan E. Whitefield MD

COGNATES REPORTED THRU MARCH 30, 1994

DATE OF ISSUE 03/30/94

TOTAL AWARD COGNATES

ACTIVITY DATE	CODE	CME ACTIVITY	CREDITED COGNATE HOURS	ADDITIONAL COGNATE HOURS	TOTAL AWARD COGNATES	
					CAT I	CAT II
02/21/90	01	POSTGRADUATE COURSE/MEETING	3	0		3
05/06/90	12	ACOG SPONSORED COURSE/MEETING	12	0		15
05/10/90	12	ACOG SPONSORED COURSE/MEETING	6	0		21
05/10/90	12	ACOG SPONSORED COURSE/MEETING	17	0		38
08/03/90	01	POSTGRADUATE COURSE/MEETING	8	0		46
11/29/90	13	INTERACTIONS	3	0		49
11/30/90	13	INTERACTIONS	3	0		52
12/31/90	11	OTHER AUDIO/VIDEO PROGRAMS	26	0		78
12/31/90	07	ACOG UPDATE TAPES	30	0		108
12/31/90	33	VOLUNTARY FACULTY	24	0		108
02/06/91	06	HOSPITAL TRAINING SESSIONS	2	0		110
04/05/91	01	POSTGRADUATE COURSE/MEETING	5	0		115
04/25/91	13	INTERACTIONS	3	0		118
04/26/91	13	INTERACTIONS	3	0		121
04/27/91	13	INTERACTIONS	3	0		124
04/28/91	13	INTERACTIONS	3	0		127
04/29/91	13	INTERACTIONS	3	0		130
04/30/91	13	INTERACTIONS	3	0		133
06/30/91	13	INTERACTIONS	3	0		136
08/02/91	06	HOSPITAL TRAINING SESSIONS	9	0		145
12/31/91	06	HOSPITAL TRAINING SESSIONS	2	0		147
12/31/91	33	VOLUNTARY FACULTY	24	0		147
03/27/92	01	POSTGRADUATE COURSE/MEETING	5	0		152
05/08/92	03	PROLOG	25	0		177
<hr/>						
09/20/93	13	INTERACTIONS	30	0		30

REMINDER: THIS IS THE LAST YEAR TO REPORT COGNATES FOR CYCLE BEGINNING 1990

Total of 123

SUMMARY OF COGNATE HOURS FOR PRIMARY CYCLE

REPORTING YEARS	CAT. I	CAT. II	TOTAL
1990	108	24	132
1991	39	24	63
1992	30		30

AWARD EARNED

APR/1993

225

TOTAL COGNATE HOURS THIS CYCLE

SUMMARY OF COGNATE HOURS FOR SECONDARY CYCLE

REPORTING YEARS	CAT. I	CAT. II	TOTAL
1993	30		30
1994			0
1995			0

30

TOTAL COGNATE HOURS THIS CYCLE



716001

NEW MEXICO BOARD OF MEDICAL EXAMINERS SECTION C  
491 Old Santa Fe Trail  
Second Floor, Lamy Building  
Santa Fe New Mexico 87501

RECEIVED  
JUN 09 1997

Gary E. Johnson  
GOVERNOR

TRIENNIAL LICENSE RENEWAL  
JULY 1, 1997 - JUNE 30, 2000

LIVINGSTON PARSONS, M.D.  
MEDICAL EXAMINER  
PRESIDENT

RENEWALS DUE ON OR BEFORE JULY 1, 1997. §61-6-26 (A)-(F) NMSA 1978.  
THERE ARE SUBSTANTIAL PENALTIES FOR LATE RENEWALS. §61-6-19 NMSA 1978.

JAN E WHITEFIELD, M.D.  
4115 LAKE OTIS PKWY  
ANCHORAGE AK 99508-5213  
- - BUSINESS PHONE

ADDRESS CORRECTION REQUESTED  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OUT OF STATE PHYSICIANS - PROVIDE NEW MEXICO BUSINESS ADDRESS, IF ANY.  
NM BUS ADDR: \_\_\_\_\_ CITY/ST/ZIP \_\_\_\_\_

**FEES:** ACTIVE STATUS \_\_\_\_\_ \$310.00 INACTIVE STATUS \_\_\_\_\_ \$25.00  
(A LICENSEE ON INACTIVE STATUS MAY NOT PRACTICE MEDICINE NOR WRITE PRESCRIPTIONS.) REINSTATEMENT OF AN INACTIVE LICENSE WITHIN A PERIOD OF TWO YEARS FROM THE RENEWAL DATE IS A FAIRLY SIMPLE PROCESS. REINSTATING AFTER TWO YEARS, REQUIRES A REINSTATEMENT APPLICATION AND BOARD APPROVAL.

IT IS THE LICENSEE'S RESPONSIBILITY TO NOTIFY THE BOARD OF CHANGES IN ADDRESS OF EITHER BUSINESS OR HOME. §61-6-28 NMSA 1978. PLEASE REVIEW INFORMATION PROVIDED, MAKE CORRECTIONS AND ANSWER ALL QUESTIONS ON BACK.

LICENSE #	SOCIAL SECURITY #	DEA #	DATE OF BIRTH
81-341	[REDACTED]	[REDACTED]	[REDACTED], 1945

HOME ADDRESS: [REDACTED]	ADDRESS CORRECTION REQUESTED _____ _____
-----------------------------	--

**OTHER STATE LICENSES GRANTED WITHIN THE PAST 3 YEARS:**

STATE <u>TX</u> # <u>G-9270</u>	STATE <u>ALASKA</u> # <u>AA 3068</u>	STATE #
---------------------------------	--------------------------------------	---------

ABMS SPECIALTY (1) OBSTETRICS AND GYNECOLOGY	BD CERTIFIED? <u>No</u>
ABMS SPECIALTY (2)	BD CERTIFIED? <u>Yes</u>

*Meatfred 1995*

**PHYSICIAN ASSISTANTS/NURSE PRACTITIONERS UNDER YOUR SUPERVISION:**

PA'S -  
NP'S - C. MORKAL, B. MORTON, C. Bonney, M. Ross

<b>HOSPITAL PRIVILEGES:</b> PROVIDENCE HSP HUMANA HSP KODIAK ISLAND HSP	<b>ADDITIONAL HOSPITAL PRIVILEGES:</b> <u>Valley Hospital - Palmer, AK</u> _____ _____
--	---

ADMINISTRATION (505) 827-5022 (505) 827-7377 FACSIMILE	FINANCIAL (505) 827-6759	INVESTIGATIONS (505) 827-7362 (505) 827-8491	LICENSING (505) 827-9933 APPLICATIONS (505) 827-7317 PHYSICIAN ASSISTANT (505) 827-6784 VERIFICATIONS
--	-----------------------------	--	--

OVER



✓  
The following questions request information that has developed since you submitted your original license/registration application to the Board. If you answer "yes" to any of the following questions, please provide an explanation:

Are you at the present time known by any other name? If so, what name? None

Have you been licensed/registered under another name(s)? If so, what name(s)? NO

Have you been denied a license/registration by a medical licensing board? Yes\_\_\_ No

Has a medical licensing board started disciplinary action against your license/registration? Yes\_\_\_ No

Have you been charged with violation of a federal, state or local statute (except minor traffic citations)? Yes\_\_\_ No

Have you had disciplinary action started against you by a hospital staff, a state or county medical society, HMO, PPO, IPA or PRO? Yes\_\_\_ No

Have you had a malpractice settlement or judgment against you? Yes\_\_\_ No

Do you have any malpractice or medically related claims or lawsuits pending against you? Yes  No\_\_\_

Have you had, during the past five years, personal or legal problems with narcotics, alcohol or other dangerous drugs? (If you are now participating in a Board-Approved treatment program, you may answer no.) Yes\_\_\_ No

Do you currently have a physical or psychological impairment that, in any way, affects your ability to safely practice medicine? Yes\_\_\_ No

I verify that all the above information is true and accurate.

Jan Whitefield  
Signature of Licensee/Registrant

4/21/97  
Date



**New Mexico Board of Medical Examiners**  
 491 Old Santa Fe Trail, Second Floor Lamy Building  
 Santa Fe New Mexico 87501  
 505-827-7317 [www.nmbme.org](http://www.nmbme.org) [nmbme@state.nm.us](mailto:nmbme@state.nm.us)

031322  
 CC3/0 -

Triennial Renewal 6/30/2003 - 6/30/2006

APR 28 2003

**Current Information** License # 81-341

Gender:  Male  Female

**Corrections**

DEA: [REDACTED]

Preferred Mailing Address:  
 Jan E. Whitefield, MD

[REDACTED]

Anchorage, AK 99508-5213

5/9/03 CC # OK per M.

Phone: (907) 563 7228

fax #

e-mail

Business Phone: 5052668704

Business or Public Address, if different from above:

Website:

fax #

e-mail:

**NM Physician Assistant(s) currently approved and registered with the Board under your supervision:**

**SPECIALTIES:** Obstetrics And Gynecology

Your license will expire July 1, 2003

**I request the following change in license status: (Check only one)**

- Active Status/\$310 Fee:**
- Inactive Status/\$25 Fee:** I am not practicing medicine in New Mexico. I understand that a license in inactive status does not require payment of the triennial renewal fee or compliance with CME requirements. I further understand that I may not engage in the practice of medicine or write prescriptions as long as my license is inactive.
- Retired Status/No Fee:** I am retired and no longer practice medicine in New Mexico. I understand that I may not engage in the practice of medicine or write prescriptions.
- Voluntary Lapsed Status/No Fee:** I choose not to renew my New Mexico medical license. I understand that I may not engage in the practice of medicine or write prescriptions.

**LATE RENEWALS**

All Renewals postmarked after July 1, 2003 will require documentation of 75 CME credit hours  
 Renewals postmarked after July 1, 2003 and before August 15, 2003, require payment of \$410  
 Renewals postmarked after August 15, 2003 and before October 1, 2003 require payment of \$460  
**YOUR LICENSE WILL BE SUSPENDED AFTER OCTOBER 1, 2003 IF IT IS NOT RENEWED!**

**Do not submit CME documentation unless a CME audit form is included with your renewal or if you are renewing after JULY 1, 2003.**

**Payment Information:** Fee Submitted \$ 310

Visa  Master Card  Check  Money Order

Credit Card No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

**COMPLETED**

Since the last renewal:

- 1. Has any action, including any disciplinary action, limitation, restriction, order for a competency examination, or any agreement, for any reason including rehabilitation, been taken or started by any state licensing board?
2. Has there been any denial, restriction, suspension or loss/revocation of your DEA or Controlled Substance license?
3. Have you been treated for use or misuse of any chemical substance or alcohol (if you are currently a voluntary participant in a Board approved monitoring program you may answer "No.")?
4. Do you have any medical or mental condition that in any way impairs or limits your ability to safely practice medicine?
5. Have you been denied a license in another state?
6. Are you currently more than a month in arrears in court-ordered child support payments in New Mexico or in any other state?
7. Have you been reported to the National Practitioner Data Bank?
8. Have you been arrested, convicted of, or pled no contest to a crime?
9. Have there been any malpractice court judgments or awards (settlements, arbitrations, mediations) against you?

If you answered "Yes" to any of the above, please provide a complete written explanation with this application.

Practice Information:

- 1. Do you practice full-time in New Mexico?
If yes, estimate the % of time you spend in the following areas (total = 100): Direct patient care, Indirect patient care, Administration, Teaching, Research, other
2. Do you practice part-time in New Mexico?
If yes, estimate the % of time you spend in the following areas (total = <100): Direct patient care, Indirect patient care, Administration, Teaching, Research, other
3. Are you retired but maintain an active license?
4. Please indicate number of work location(s)
Office(s), Clinic(s), Hospital(s), City(s)/Town(s), Rural

Physician Practice Information data will not be identified to any other person or institution.

(Check only one)

- I certify that I was licensed during 7/1/00-7/1/03 and I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC.
I have not completed a minimum of 75 CME hours as required by 16.10.4 NMAC and I am requesting an emergency deferral, of up to 90 days, as allowed under 16.10.4.15 NMAC.

Signature of Licensee (Signature stamp is not accepted)

4/24/03

Date

By signing above you are certifying, under penalty of perjury, that all information on this form is currently accurate.

\*\*Your Triennial Renewal will be returned if you DO NOT:

- Enclose correct renewal fee
Indicate fee to be charged to credit card
Sign check
Sign and date renewal form
Answer all questions and provide complete written explanations to any "yes" answers to questions 1-9
Indicate CME status
Submit acceptable documentation of CME (if Audited or renewing late)
Complete backside of renewal

NM BOARD OF MEDICAL EXAMINERS  
LAMY BUILDING-SECOND FLOOR  
491 OLD SANTA FE TRAIL  
SANTA FE NEW MEXICO 87501

AS A CONDITION OF LICENSE RENEWAL, ALL LICENSED PHYSICIANS MUST REPORT AND DOCUMENT 75 HOURS OF CONTINUING MEDICAL EDUCATION AT THE TIME OF TRIENNIAL LICENSE RENEWAL. CREDIT HOURS MAY BE EARNED AT ANY TIME DURING THE THREE YEAR REPORTING PERIOD FROM JANUARY 1994 THROUGH DECEMBER 1996.

NAME: JAN WHITEFIELD M.D. LICENSE #: 81-341

**DOCUMENTATION MUST BE ATTACHED**

**NEED ACTUAL COPIES OF ATTENDANCE CERTIFICATES-A LIST IS NOT ACCEPTABLE**

I certify that I have complied with the Continuing Medical Education requirement for renewal of my New Mexico license and that appropriate documentation is attached.

Certified AMA Category 1 Clinical Courses Credit Hours 125 hours  
New Mexico Specific Category 1 Clinical Courses Credit Hours \_\_\_\_\_

AMA Physicians Recognition Award Year \_\_\_\_\_  
 AAFP Certificate of CME Year \_\_\_\_\_

Certification or Recertification by ABMS Specialty Board Year 6/26/95

USMLE Step 3 Year \_\_\_\_\_

Internship, Residency or Fellowship Inclusive Dates: \_\_\_\_\_

Advanced Degree in Medically Related Field (40 Hours Maximum Per Year of Study) Year(s) \_\_\_\_\_ Credit Hours \_\_\_\_\_

Self Assessment Tests: Certificate of Credit Must Be Attached (No Limit) Credit Hours \_\_\_\_\_

Teaching - Medical Students Statement From Approved Medical School Must Be Attached (40 Hours Maximum Credit) Credit Hours \_\_\_\_\_

Preceptorship - Medical Students Statement From Approved Medical School Must Be Attached (30 Hours Maximum Credit) Credit Hours 24 36

Scientific Articles (10 Hours Each) Proof of Publication Must Be Attached (30 Hours Maximum Credit) Credit Hours \_\_\_\_\_

STAFF USE ONLY:  
CME'S APPROVED BY JS DATE: 6 10 97 DOC. REC.

**SEE BACK OF THIS FORM FOR DESCRIPTION OF ACCEPTABLE CME CREDITS**

# THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS



## PROGRAM FOR CONTINUING PROFESSIONAL DEVELOPMENT

**ACOG COGNATE PROGRAM**  
 409 12th Street, SW  
 PO Box 96920  
 Washington, DC 20090-6920  
 (800) 673-8444 • (202) 863-2405

# TRANSCRIPT

ACOG ID NUMBER **F 0270924**

**Jan E. Whitefield MD**  
 [Redacted]

PAGE 1  
 1

Cognates Reported Thru 03/31/1997

DATE OF ISSUE 04/01/97

ACTIVITY DATE	CODE	CME ACTIVITY	CREDITED COGNATE HOURS	ADDITIONAL COGNATE HOURS	TOTAL AWARD COGNATE	
					CAT I	CAT II
09/20/93	13	INTERACTIONS				
12/31/93	33	VOLUNTARY FACULTY	30	0	30	
12/31/94	11	OTHER SELF-INSTRUCTIONAL PRGS	24	0	30	24
12/31/94	33	VOLUNTARY FACULTY	26	0	56	
02/09/95	01	POSTGRADUATE COURSE/MEETING	24	0	56	24
03/21/95	01	POSTGRADUATE COURSE/MEETING	20	0	76	
03/23/95	01	POSTGRADUATE COURSE/MEETING	22	0	98	
06/26/95	04	ABOG RE-CERTIFICATION EXAM	14	0	112	
08/31/95	13	INTERACTIONS	40	0	152	
12/31/95	33	VOLUNTARY FACULTY	3	0	155	
01/27/97	01	POSTGRADUATE COURSE/MEETING	12	0	155	12
REMINDER: THIS IS THE LAST YEAR TO REPORT COGNATES FOR CYCLE BEGINNING 1993			3	0	3	

**SUMMARY OF COGNATE HOURS FOR PRIMARY CYCLE**

REPORTING YEARS	CAT. I	CAT. II	TOTAL
1993	30	24	54
1994	26	24	50
1995	99	12	111
<b>TOTAL COGNATE HOURS THIS CYCLE</b>			<b>215</b>

**AWARD EARNED**  
 APR/1996  
 [Redacted]

**SUMMARY OF COGNATE HOURS FOR SECONDARY CYCLE**

REPORTING YEARS	CAT. I	CAT. II	TOTAL
1996			0
1997	3		3
1998			0
<b>TOTAL COGNATE HOURS THIS CYCLE</b>			<b>3</b>

**Mohler, Barbara L., BME**

# 81-341 ✓

**From:** Jan Whitefield [redacted]@gci.net]  
**Sent:** Saturday, August 19, 2006 2:40 PM  
**To:** explain, med, BME  
**Subject:** License Renewal Questions, Jan Whitefield, MD, NM license # 81-341, question regarding malpractice cases.

**Claimant:** [redacted], 33 y/o female  
**Date/Surgery:** 11/12/2002, Laparoscopically Assisted Vaginal Hysterectomy and Bilateral Salpingo-oophorectomy.  
**Nature:** Allegation is one of failure to supply appropriate informed consent as to the consequences of a hysterectomy with bilateral oophorectomy. Suit has been filed, Case number 3AN 04-12424, in the Third Judicial District, Superior Court for the State on Alaska  
**Other named defendants:** None  
**Status:** Currently the suite is being worked up by the defense as well as the plaintiff, and is due for trial in the Spring of 2007.  
**Insurance Company:** Medical Insurance Exchange of California, 6250 Claremont Avenue, Oakland, CA 94618-1324, 1-800-227-4527  
**Defense Attorney:** Matthew K. Peterson, 711 H Street, Suite 620, Anchorage, AK 99501-3454, 902-272-9272

Submitted as a portion of the license renewal process for Jan Whitefield, MD

**Whitefield, Jan E**

81-341

**QUESTION TEXT****ANSWER****UPDATE DATE**

Since your last renewal, has your application for licensure in any jurisdiction been investigated or denied, or are any current applications pending investigation or being challenged?	N	8/19/2006
Since your last renewal, has your license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, denied or are any currently held licenses pending investigation or being challenged?	N	8/19/2006
Since your last renewal, has your DEA or Controlled Substance license in any jurisdiction been investigated, voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	8/19/2006
<li>Research (part-time):	Not	8/19/2006
<li>Teaching (part-time):	0-10%	8/19/2006
<li>Administration (part-time):	0-10%	8/19/2006
<li>Direct patient care (part-time):	81-90%	8/19/2006
<li>Other (part-time):	Not	8/19/2006
<li>Clinic(s):	Not	8/19/2006
<li>City(s)/Town(s):	Not	8/19/2006
If you practice in New Mexico please indicate number of work location(s): <li>Office(s):	Not	8/19/2006
<li>Hospital(s):	Not	8/19/2006
<li>Rural:	Not	8/19/2006
<li>Other:	Not	8/19/2006
Do you practice part-time in New Mexico? <font color = red> * </font>  If yes, estimate the % of time you spend in the following areas (total = <100):	Y	8/19/2006
Are you retired but maintain an active license? <font color = red> * </font>	N	8/19/2006
<li>Administration:	Not	8/19/2006
<li>Teaching:	Not	8/19/2006
<li>Research:	Not	8/19/2006
Please select a statement that <b>BEST</b> describes your practice:<font color = red> * </font>	Engaged	8/19/2006
Do you practice full-time in New Mexico? <font color = red> * </font>  If yes, estimate the % of time you spend in the following areas (total = 100):	N	8/19/2006
<li>Direct patient care:	Not	8/19/2006
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	8/19/2006
Since your last renewal, have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records?	N	8/19/2006
Since your last renewal, have you resigned from a healthcare entity to avoid investigation, modification, suspension, or termination of privileges?	N	8/19/2006
Since your last renewal, has your professional liability carrier excluded any specific procedures from your coverage?	N	8/19/2006
Since your last renewal, have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	8/19/2006
Since your last renewal, have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	8/19/2006
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.	N	8/19/2006
Since your last renewal, has your professional liability coverage been terminated by action of the insurance company?	N	8/19/2006
Since your last renewal, have you been denied professional liability insurance coverage?	N	8/19/2006
Have you been treated for mental or significant medical illness during the past five years? If yes, please have your treating physician provide the NM Medical Board with a letter regarding your diagnosis and treatment.	N	8/19/2006



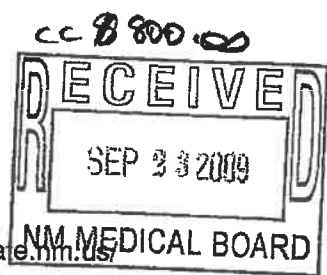
**New Mexico Medical Board**

2055 S Pacheco Street

Building 400

Santa Fe New Mexico 87505

Voice 505-476-7227 fax 505-476-7233 website <http://nmmb.state.nm.us/>



**Triennial Renewal 7/01/2009 – 7/01/2012 Renewal Fee \$600**

**Current Information**

Gender: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	License # <u>81-341</u>	DEA#: <span style="background-color: black; color: black;">[REDACTED]</span>
Preferred Mailing Address:		Please make corrections below.
Jan E Whitefield, MD		
<span style="background-color: black; color: black;">[REDACTED]</span>		
Business Phone: 9075637228		
Fax #: <u>907-563-5027</u>		
E-Mail Address: whitefield@gci.net		
Business Address:		
4115 Lake Otis Pkwy		
Anchorage AK 99508-85213		

**NM Physician Assistant(s) currently approved and registered with the Board under your supervision:**

**Your license will expire July 1, 2009**

**I request the following change in license status: (Check only one)**

- Active Status/\$600 Fee:** 800
- Inactive Status/\$25 Fee:** I am not practicing medicine in New Mexico. I understand that a license in inactive status does not require payment of the triennial renewal fee or compliance with CME requirements. I further understand that I may not engage in the practice of medicine or write prescriptions as long as my license is inactive.
- Retired Status/No Fee:** I am retired and no longer practice medicine in New Mexico. I understand that I may not engage in the practice of medicine or write prescriptions.
- Voluntary Lapsed Status/No Fee:** I choose not to renew my New Mexico medical license. I understand that I may not engage in the practice of medicine or write prescriptions.

**LATE RENEWALS**

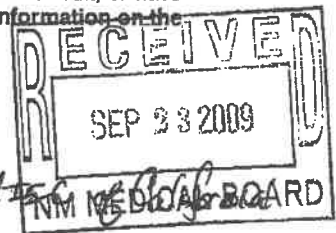
All Renewals postmarked after July 1, 2009 will require documentation of 75 CME credit hours.  
 Renewals postmarked after July 1, 2009 and before August 15, 2009, require payment of \$700.  
 Renewals postmarked after August 15, 2009 and before October 1, 2009 require payment of \$800.  
**YOUR LICENSE WILL BE SUSPENDED AFTER OCTOBER 1, 2009 IF IT IS NOT RENEWED!**

**Do not submit CME documentation unless you are renewing after JULY 1, 2009.**

**PAYMENT INFORMATION PAGE ATTACHED**



**ALL QUESTIONS MUST BE ANSWERED**

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?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
2. Since your last renewal have you been denied professional liability insurance coverage?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
7. Have you ever been named as a defendant in any criminal proceedings?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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).	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
b. Since your last renewal are any currently held licenses pending investigation or being challenged?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you received written notice of intent to file such a suit? <b>If yes, please provide the following information on the attached Malpractice History form for each case:</b> Name, age, sex of patient/claimant. <ul style="list-style-type: none"> <li>Date(s) and type of treatment and/or surgery, which led to the allegations against you.</li> <li>Nature of allegations in claims/suits. Specify whether a suit was ever filed.</li> <li>Names of other practitioners and hospital, if any, involved in claims or suit.</li> <li>Disposition or current status of claim or suit (be specific).</li> <li>Name of insurance carrier defending you.</li> <li>Name of defense attorney.</li> </ul>		
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
18. Since your last renewal 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? <b>If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.</b>	[REDACTED]	
19. a. Are you currently ABMS Certified?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
b. Do you hold lifetime certification?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
c. Do you hold time limited certification?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
20. 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?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

*If you answered "Yes" to any of the above questions 1-18, please provide a complete written explanation with this application.*

**Practice Information:**

1. Do you practice full-time in New Mexico? .....  Yes  No  
If yes, estimate the % of time you spend in the following areas (total = 100): Direct patient care \_\_\_\_%  
Administration \_\_\_\_%; Teaching \_\_\_\_%; Research \_\_\_\_%; other \_\_\_\_%
2. Do you practice part-time in New Mexico? .....  Yes  No  
If yes, estimate the % of time you spend in the following areas (total = <100): Direct patient care \_\_\_\_%  
Administration \_\_\_\_%; Teaching \_\_\_\_%; Research \_\_\_\_%; other \_\_\_\_%
3. Are you retired but maintain an active license? .....  Yes  No
4. Please indicate number of work location(s)  
Office(s): 1  2 3 4 5 6 ≥7      Clinic(s):  1 2 3 4 5 6 ≥7      Hospital(s): 1 2  3 4 ≥5  
City(s)/Town(s): 1  2 3 4 ≥5      Rural: 1 2 3 4 ≥5

*Physician Practice Information data will not be identified to any other person or institution.*

- I have not completed a minimum of 75 CME hours as required by 16.10.4 NMAC and I am requesting an emergency deferral, of up to 90 days, as allowed under 16.10.4.15 NMAC. I understand I will be assessed a late renewal penalty fee of \$100 between 7/1/09-8/15/09 or \$200 between 8/16/09-10/1/09 if my CME is not completed and submitted to the Board by July 1.

*Jan E. Whitefield MD*

*9/15/09*

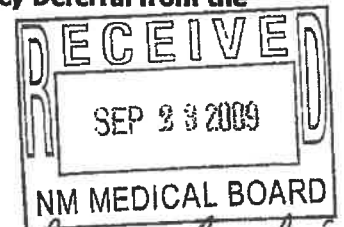
**Signature of Licensee** (Signature stamp is not accepted)

**Date**

*By signing above you are certifying, under penalty of perjury, that all information on this form is currently accurate.*

**\*\*Your Triennial Renewal will be returned if you DO NOT:**

- o Enclose correct renewal fee
- o Indicate fee to be charged to credit card
- o Sign check
- o Sign and date renewal form
- o Answer all questions and provide complete written explanations to any "yes" answers to questions 1-19
- o If you answered "NO" to question 20, and are unable to complete the required CME hours prior to the date of license expiration, you may request for an Emergency Deferral from the Board on this signature page above.
- o Submit acceptable documentation of CME (if renewing late)
- o Complete backside of renewal



#15. Enclosed is a copy of the settlement of a malpractice claim settled 11/4/07 by mediation. All claims of malpractice were denied. The court stipulated the surgery technique did not fall below the STANDARD OF CARE.

#16. The enclosure is notification to the Alaska State Medical Board. A similar statement was submitted to the National Practitioners DATA BANK.

#19. In OB/gyn annual recertification is required. I am currently certified through 12/31/09.

## 2009 TRIENNIAL LICENSE RENEWAL APPLICATION INSTRUCTIONS

**\*PLEASE RENEW YOUR LICENSE IN MAY:** Your license expires July 1, 2009. An expired license **is not** valid for practice in New Mexico. If you are currently working in New Mexico please submit your renewal no later than May 31, 2009, to assure that you receive your license by July 1. Please renew early to avoid delays!

**NAME:** Your name is as it will appear in the Physician Roster and the NMMB web site. If we have you listed as "Robert J." and you are known as "R. James" please let us know.

**OFFICE/PUBLIC ADDRESS:** The office address will appear in the Physician Roster. Every physician must have an address available to the public. If only a home address is provided, it becomes the public address of record.

**HOME ADDRESS:** The home address is confidential unless it is the only address provided.

**You are required to notify the Board in writing of any changes in office or home addresses.**

**The Board assumes no responsibility for renewal applications not received by the licensee for any reason.**

**PHYSICIAN ASSISTANT(S):** List the names of any Physician Assistant(s) currently approved and registered with the Board under your primary supervision or where you serve as an alternate supervising physician.

**FEES/PAYMENT:** You may pay by check, money order or credit card (Visa or Master Card). Make checks payable to the **New Mexico Medical Board or NMMB**.

**RENEWAL AFTER JULY 1 AND BY AUGUST 15:** Renewal applications post-marked or hand delivered after July 1 and by August 15 will be assessed a late fee of \$100 in addition to the \$600 renewal fee.

**RENEWAL BETWEEN AUGUST 16 AND OCTOBER 1:** Renewal applications post-marked or hand delivered between August 16 and October 1 will be assessed a late fee of \$200 in addition to the \$600 renewal fee.

**LICENSE SUSPENSION FOR NON-RENEWAL:** The Board shall summarily suspend the license of any physician who has failed to renew their license, change the license status, pay all required fees, comply with Continuing Medical Education requirements, or provide required documentation by October 1, 2009.

**REQUEST FOR CHANGE IN LICENSE STATUS:** You may request your license be placed on Inactive, Retired, or Voluntarily Lapsed status.

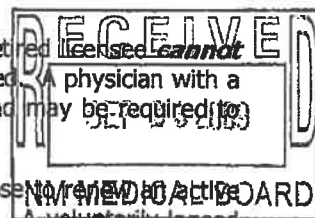
**INACTIVE STATUS:** Requires a completed renewal application and \$25 processing fee prior to October 1, 2009. A license in inactive status is **not** valid for practice in New Mexico but may be reinstated in accordance with the provisions of 16.10.7.16 NMAC through 10.7.18 NMAC.

**RETIRED STATUS:** Upon written request, a license may be placed on retired status. A retired licensee **cannot** practice medicine with a retired license, and such license **may not** subsequently be reinstated. A physician with a retired license who chooses to practice in New Mexico must re-apply as a new applicant and may be required to take an examination to demonstrate current competence.

**VOLUNTARILY LAPSED STATUS:** A physician may inform the Board that they do not choose to renew their license to practice medicine in New Mexico and will voluntarily allow the license to lapse. A voluntarily lapsed license is **not** valid for practice in New Mexico but may be reinstated in accordance with the provisions of 16.10.7.16 NMAC through 10.7.18 NMAC.

**QUESTIONS/Since your last renewal:** If you answered, "YES" to any of the questions (1-18), you must include a written explanation with your renewal application.

**CME:** All physicians are required to certify compliance with the mandatory **75 AMA Category 1 hours of Continuing Medical Education (CME)** requirements. Ten percent of renewals will be randomly audited after renewal. Individuals renewing after July 1 are automatically subject to audit and must provide proof of CME in accordance with the provisions of 16.10.4.10 through 16.10.4.14 NMAC. *See back of form for additional CME information.* If you are unable to fulfill the CME requirements prior to July 1, 2009, you must request an emergency deferral in accordance with provisions of 16.10.4.15 NMAC.



## CONTINUING MEDICAL EDUCATION

**Seventy-five hours (75) of CME are required during each three-year renewal cycle. CME may be earned at any time during the licensing period, between July 1, 2006 and June 30, 2009.**

**AUDIT: 10%** of all licensed physicians will be randomly selected to submit proof of 75 AMA Category 1 hours of CME. If you receive a CME **Audit Form**, please submit copies of CME certificates or other acceptable documentation. If you do not receive an audit form please do **NOT** send CME documentation.

**The following is a list of accepted Continuing Medical Education credits:**

**AMA CATEGORY 1 or NM CATEGORY 1:** AMA Physician Recognition Award (PRA) or courses sponsored by an accredited AMA provider. *Acceptable documentation includes photocopies of original certificates or official letters from the course sponsor or online provider.*

**SPECIALTY CERTIFICATION:** American Academy of Family Physicians (AAFP) Certificate of Continuing Education or Initial certification or re-certification by an ABMS approved specialty board. This can only be used if the certification or re-certification was obtained during the licensing-CME period (7/1/06 through 6/30/09).

**POST GRADUATE EDUCATION:** A maximum of seventy-five (75) credit hours are allowed for participation in a postgraduate education program, which has been approved by the Board or by the American Medical Association Liaison Committee on Graduate Medical Education. Postgraduate CME hours must be documented and attested either by the dean of the medical school, the chief of service, the course director, or an equivalent authority. Postgraduate education programs include internships, residencies and fellowships.

**ADVANCED DEGREES:** Forty (40) credit hours are allowed for each full academic year of study toward an advanced degree in a medical field or a medically related field as approved by the Board. Advanced degree studies must be documented and attested either by the dean of the medical school, the chief of service, the course director, or an equivalent authority.

**SELF-ASSESSMENT TESTS:** Self-assessment examinations certified for AMA Category 1 by an accredited sponsor of Continuing Medical Education are acceptable if the examination is scored by an educational entity approved by the Board, and is documented with photocopies of signed attestation from the educational entity.

**TEACHING:** One credit hour is allowed for each hour of teaching medical students or physicians in the United States medical school, an approved internship or residency or for teaching in other programs approved by the Board for a maximum of forty (40) credit hours in any three year reporting period. Teaching hours must be documented and attested either by the dean of the medical school, the chief of service, the course director, or an equivalent authority.

**PHYSICIAN PRECEPTORS:** A maximum of thirty (30) hours of credit during a three year reporting period is acceptable for licensed physicians who are acting as preceptors for students enrolled in an accredited medical school. Preceptor hours must be documented and attested either by the dean of the medical school, the chief of service, the course director, or an equivalent authority.

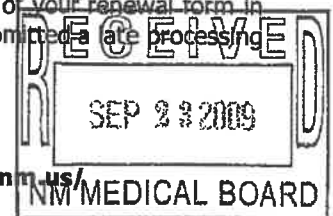
**PAPERS AND PUBLICATIONS:** Ten (10) hours of credit are allowed for each original scientific medical paper or publication written by a licensee. For acceptance, paper must have been presented to a recognized national, international, regional or state society, or organization whose membership is primarily physicians; or must have been published in a recognized medical or medically related scientific journal. Material used in a paper or publication may be given credit one time. A maximum of thirty (30) hours credit may be claimed for publications.

**CARDIO-PULMONARY RESUSCITATION:** Credit, one hour per instructional hour, may be claimed for ACLS, PALS, ATLS and NALS.

**EMERGENCY DEFERRAL:** If you were unable to complete the required 75 CME hours prior to the date of license expiration you may request an emergency deferral from the Board on the signature page of your renewal form in accordance with the provisions of 16.10.4.15 NMAC. At the time the required CME are submitted a late processing fee will be charged per 16.10.9.8 NMAC.

If you have any question, contact the Board Office 505-476-7220.

**Board Rules may be accessed on our website: <http://nmb.state.nm.us/>**



Return to My ACOG :

**The American College of Obstetricians  
and Gynecologists**

**PROGRAM FOR CONTINUING PROFESSIONAL  
DEVELOPMENT**



**ACOG COGNATE PROGRAM**

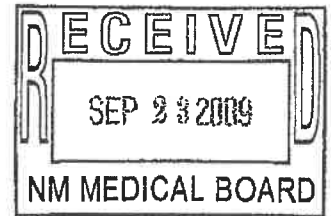
**TRANSCRIPT**

409 12th Street, SW  
PO Box 96920  
Washington, DC 20090-6920  
(800) 673-8444 - (202) 863-2543  
fax: (202) 484-1586  
e-mail: [cognates@acog.org](mailto:cognates@acog.org)

*Records of CME  
generated by ACOG.*

ACOG ID Number: F 000270924I

Jan E. Whitefield MD



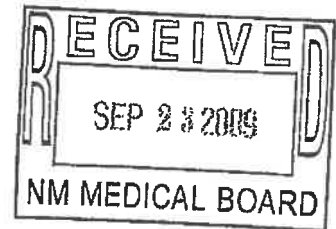
**Cognates Posted September 2, 2009**

Activity Date	Code	ACOG/ACCME Approved Category 1 Activity	COGNATE Credits	Cumulative Total by Cycle
01/04/2005	1250	ACOG Webinar	2.00	2.00
04/26/2005	01	ACCME COURSE/MEETING	4.00	6.00
06/03/2005	01	ACCME COURSE/MEETING	7.00	13.00
06/04/2005	01	ACCME COURSE/MEETING	4.00	17.00
07/17/2005	1600	ACCME ETHICS/PROFESSIONAL RESP	2.00	19.00
11/01/2005	1250	ACOG Webinar	2.00	21.00
11/04/2005	01	ACCME COURSE/MEETING	4.00	25.00
04/07/2006	01	ACCME COURSE/MEETING	16.00	41.00
05/13/2006	01	ACCME COURSE/MEETING	12.00	53.00
08/19/2006	1600	ACCME ETHICS/PROFESSIONAL RESP	2.00	55.00
09/22/2006	01	ACCME COURSE/MEETING	8.00	63.00
09/23/2006	01	ACCME COURSE/MEETING	4.00	67.00
10/13/2006	01	ACCME COURSE/MEETING	22.00	89.00
05/01/2007	1250	ACOG Webinar	2.00	91.00
08/12/2007	1220	ACOG DISTRICT MEETING	23.00	114.00
12/31/2007	04	ABOG RE-CERTIFICATION EXAM	35.00	149.00
<hr/>				
06/20/2008	1240	ACOG JOINT SPONSORED MEETING	7.00	7.00
06/21/2008	1240	ACOG JOINT SPONSORED MEETING	7.00	14.00
06/22/2008	1240	ACOG JOINT SPONSORED MEETING	4.00	18.00
12/14/2008	01	ACCME COURSE/MEETING	16.75	34.75
12/31/2008	04	ABOG RE-CERTIFICATION EXAM	35.00	69.75
03/21/2009	01	ACCME COURSE/MEETING	18.00	87.75
03/29/2009	11	ACCME SELF-INSTRUCT'L PROG	12.00	99.75

04/02/2009	4033	CU-V8I1-POLYCYSTIC OVARY SYNDROME	5.00	104.75
<b>This is the last year to report Cognates for Cycle beginning 2005</b>				

<b>Summary of Category 1 COGNATE Credits for Primary Cycle</b>		<b>Summary of Category 1 COGNATE Credits for Secondary Cycle</b>	
Reporting Years	Total COGNATE Credits	Reporting Years	Total COGNATE Credits
2005	25.00	2008	69.75
2006	64.00	2009	35.00
2007	60.00	2010	0.00
<b>Total COGNATE Credits This Cycle</b>	<b>149.00</b>	<b>Total COGNATE Credits This Cycle</b>	<b>104.75</b>

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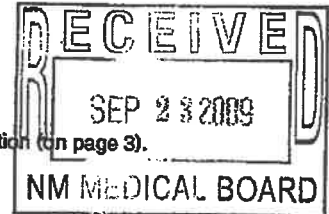


**ALASKA STATE MEDICAL BOARD**  
 Department of Community and Economic Development  
 Division of Occupational Licensing  
 550 W 7<sup>th</sup> Avenue – Suite 1500  
 Anchorage AK 99501-3567  
 Telephone: 907/269-8163

**REPORT OF MALPRACTICE CLAIM SETTLEMENT**

Please read instructions carefully:

- 1) PLEASE PRINT CLEARLY. Incomplete or illegible reports will be returned.
- 2) Answer all questions in the form.
- 3) Return the completed form to the letterhead address.
- 4) DO NOT USE PATIENT NAME TO IDENTIFY CASE.
- 5) Submit your report within 30 days following the settlement of a case. Refer to statutes and regulation (on page 3).
- 6) Social security number for identification purposes only – not released to the public.



**PART I IDENTIFICATION INFORMATION**

NAME (Last, First, Middle) Whitefield, Jan E.	
ADDRESS [REDACTED]	
CITY, STATE, ZIP Anchorage, AK 99508	
TELEPHONE – DAY [REDACTED]	TELEPHONE – FAX (907)563-6278
ALASKA LICENSE NUMBER No. S 3068 <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> PA-C	SOCIAL SECURITY NUMBER [REDACTED]

**PART II CLAIM INFORMATION**

Case/Claim/ Court/Chart Number: 3AN-04-12424C1      Date(s) of Occurrence: 11/12/02      Date of Award/ Settlement: 10/4/07

Total Amount of Award/Settlement\*: [REDACTED]

\* If the amount is subject to a confidentiality order, a copy of the court order or other agreement must be attached to this report.

Type of Payment (check one):  One-Time Lump Sum       Monthly Annuity       Structured Settlement       Other

Type of Award/Settlement (check one):  CA (Court Award)       PC (Private Compromise)

SET-A (Settlement after initiation civil action)       SET-B (Settlement before initiation civil action)

Location of Medical Records (Indicate hospital, doctor's office, etc.): Alaska Women's Health Services

Complete description of the alleged malpractice case including the duration of physician-patient relationship, frequency of patient contacts, any external factors that have bearing on the case, duration of patient-physician relationship, initial diagnosis, treatment plan, follow-up by both the physician and patient, and other pertinent information (300 words or less). Attach additional page if needed.

**PART III ALLEGATION**

Describe the nature of the allegation of the malpractice claim.

Plaintiff was my patient from October of 2002 through January of 2003. I am a gynecologist. I performed a laparoscopy assisted vaginal hysterectomy and salpingo-oophorectomy procedure on Plaintiff on November 12, 2002, to relieve pelvic pain and bleeding. The preoperative diagnosis was menometrorrhagia. Complications and neurological problems occurred following the procedure,

including urinary retention experienced postoperatively and, later, constipation, bowel incontinence, and lack of sensation in the genital area and these conditions have required further medical treatment. Plaintiff claimed that the surgery was performed in a negligent manner and that I had failed to obtain proper consent and that she suffered damages as a result of my acts or omissions.

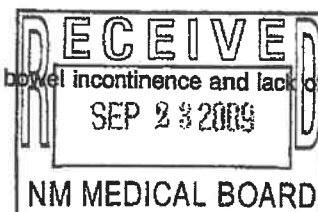
**PART IV LICENSEE'S DESCRIPTION OF CASE** Complete description of the alleged malpractice case including the duration of patient-physician relationship, frequency of patient contacts, any external factors that have bearing on the case, duration of patient-physician relationship, initial diagnosis, treatment plan, follow-up by both the physician and patient, and other pertinent information (300 words or less). Attach additional page if needed.

On October 23, 2002, I saw Plaintiff upon referral from Dr. Laura Walters and/or Dr. Souza. The consultation addressed her heavy, painful menstrual periods. She had already attempted conservative treatment including birth control pills and hormone therapy. Those records had been faxed to me earlier. I took a detailed history. I discussed the treatment options, including surgical options with Plaintiff. I recommended medical treatment, which would also be a diagnostic modality, which she declined. Plaintiff desired a definitive treatment for her problem. I discussed these options with her and, after she was informed of the alternatives, including the risks and benefits of surgery, she chose to have a hysterectomy.

On November 8, 2002, I met with Plaintiff again and discussed the common risks and the surgery, including bleeding, infection, bowel and bladder injury, anesthesia and failure of the treatment. She consented to the treatment.

The surgical procedure was conducted on November 12, 2002. Prior to the procedure, I again discussed the surgery risks, including anesthesia, infection, bleeding and injury to the bowel and bladder. The surgery was a laparoscopically assisted vaginal hysterectomy with a bilateral salpingo-oophorectomy. (LAVH/BSO) The surgery was performed in a standard, reasonable and appropriate manner. There were no complications. After the surgery Plaintiff experienced post-operative problems involving urinary retention. She was discharged with a catheter on 11/15/02 and returned to her home in Kodiak. She was then referred to Dr. Tomera, an urologist, who assumed her care for this problem. Plaintiff was diagnosed with Fowler's Syndrome, described as similar to Reflex Sympathetic Dystrophy (RSD) of the bladder. This is a very rare condition. The etiology of this condition is unknown, both in general and specifically in this case. A temporary nerve stimulator was placed, and later a permanent one inserted, underneath the skin in the sacral area. These had some success in relieving symptoms.

Plaintiff also reported other symptoms that succeeded the LAVH/BSO, including constipation, bowel incontinence and lack of feeling in her thigh and genital area.



**PART V LICENSEE'S RESPONSE TO ALLEGATIONS** Licensee's response to allegations including extenuating factors, complications, and other pertinent information (attach additional page if needed):

On November 12, 2002, I performed a necessary and appropriate laparoscopy assisted vaginal hysterectomy and salpingo-oophorectomy procedure on Plaintiff to relieve pelvic pain and bleeding. Previous to surgery I had discussed with Plaintiff non-surgical options and the risks of this surgery as well as consequences of removal of ovaries. The informed consent obtained was reasonable and met the standard of care as set forth by Alaska statute. This Court ruled on my motion for summary judgment that my surgical technique did not fall below the standard of care. I have denied all claims of negligence and malpractice.



Physician  
Signature

*Jane Whitfield*

Date

*11/19/07*

NOTARY VERIFICATION:

SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for the State of

*Alaska*

this

*19<sup>th</sup>*

day of

*November 2007*

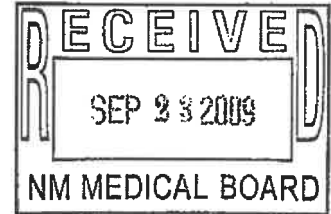
Notary Signature

*B Kelley Cowgill*

My commission expires:

*December 25, 2010*

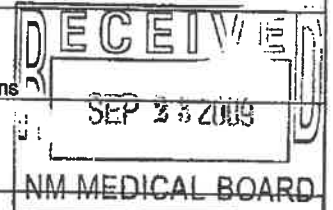
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## PART VI

## STAFF AND BOARD REVIEW

STAFF REVIEW:	DATE:
Signature	
ENTERED IN LICENSE DATABASE:	BY:
Date:	
REVIEWED BY BOARD	
Meeting of:	
RECOMMENDATION OF BOARD:	
<input type="checkbox"/> No further action required <input type="checkbox"/> Additional Information Required <input type="checkbox"/> Refer to Investigations	
RETURNED TO BOARD WITH ADDITIONAL INFORMATION:	
Meeting of:	
FOLLOW UP LETTER SENT:	
<input type="checkbox"/> Closure, no further action <input type="checkbox"/> Referred to Investigations for further inquiry	



**Sec. 08.64.130. Board records.** (a) The board shall preserve a record of its proceedings, which must contain the name, age, residence and duration of residence of each applicant for a license, the time spent by the applicant in medical study, the place of medical study, and the year and school from which degrees were granted. The record must also show whether the applicant was granted a license or rejected.

(b) The board shall maintain records for each person licensed under this chapter concerning the outcome of malpractice actions and claims as reported under AS 08.64.200(a) and 08.64.345. The board shall periodically review these records to determine if the licensee should be found to be professionally incompetent under AS 08.64.326(a)(8)(A).

(c) The board shall make available to the public the information maintained under (a) and (b) of this section for each person licensed under this chapter.

**Sec. 08.64.345. Reports relating to malpractice actions and claims.** A person licensed under this chapter shall report in writing to the board concerning the outcome of each medical malpractice claim or civil action in which damages have been or are to be paid by or on behalf of the licensee to the claimant or plaintiff, whether by judgment or under a settlement. This report shall be made within 30 days after resolution of the claim or termination of the civil action.

**12 AAC 40.930. Requirements for Reporting the Outcome of Malpractice Claims or Actions.** (a) A person licensed under this chapter shall submit to the board a signed, notarized report on a form provided by the department, explaining the outcome of each malpractice claim or action against the licensee in which damages have been or are to be paid, whether by judgment or settlement. Reports shall be submitted to the board within 30 days of the date of the resolution of the claim or action.

(b) Malpractice reports shall include the

- (1) name and address of the licensee;
- (2) telephone number of the licensee;
- (3) date of the occurrence;
- (4) summary of the alleged malpractice;
- (5) summary of the licensee's response to the allegations;
- (6) case, claim, or court number of the malpractice claim or action; if a court action was not filed, the medical record or chart number, and the location of the records relating to the alleged malpractice;
- (7) amount of the award or settlement paid or to be paid by or on behalf of the licensee;
- (8) date of award or settlement;
- (9) following type of resolution of the claim or action:
  - (A) court or jury award;
  - (B) settlement following initiation of civil court action;
  - (C) settlement before the initiation of civil court action;
  - (D) other private compromise.

(c) Failure to submit a malpractice report required by this section constitutes unprofessional conduct under 12 AAC 40.967 and is subject to disciplinary action by the board.

#### CONFIDENTIAL SETTLEMENTS:

Please note that most confidential settlements have a provision that the details of such settlements will be confidential unless required to be disclosed by law. These statutes and regulations require disclosure to the medical board regardless of the nature of the settlement. If the amount is subject to a confidentiality order from a court, a copy of the court order must be provided with the form when submitting the report. Since the information maintained by the board is subject to release to the public upon request, in order to comply with a court ordered confidentiality clause, we must have a copy of the court order on file.

ACOG COGNATE REPORT



81-341

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**ACOG COGNATE PROGRAM**

**TRANSCRIPT**

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(800) 673-8444 - (202) 863-2405  
fax: (202) 484-1586  
e-mail: [cognates@acog.org](mailto:cognates@acog.org)

ACOG ID Number: F 0270924

Jan E. Whitefield MD



**Cognates Posted 08-15-06**

Activity Date	Code	ACOG/ACCME Approved Category I Activity	COGNATE Credits	Cumulative Total by Cycle
03/07/2002	01	ACCME COURSE/MEETING	3	3
04/06/2002	01	ACCME COURSE/MEETING	11	14
06/07/2002	11	ACCME SELF-INSTRUCT'L PROG	4	18
08/10/2002	01	ACCME COURSE/MEETING	18	36
08/11/2002	1600	ACCME ETHICS/PROFESSIONAL RESP	2	38
02/01/2003	01	ACCME COURSE/MEETING	16	54
02/22/2003	01	ACCME COURSE/MEETING	12	66
04/23/2003	11	ACCME SELF-INSTRUCT'L PROG	4	70
06/22/2003	08	ACOG SELF-INSTRUCT'L PROGRAM	20	90
08/03/2003	1600	ACCME ETHICS/PROFESSIONAL RESP	2	92
10/04/2003	01	ACCME COURSE/MEETING	12	104
04/14/2004	01	ACCME COURSE/MEETING	6	110
05/01/2004	1206	ACOG ACM 060 COURSE	6	116
05/02/2004	1206	ACOG ACM 060 COURSE	6	122
05/05/2004	1217	ACOG ANNUAL CLINICAL MEETING	18	140
05/05/2004	1206	ACOG ACM 060 COURSE	6	146
07/29/2004	1600	ACCME ETHICS/PROFESSIONAL RESP	2	148
10/05/2004	1250	ACOG Webinar	2	150
11/02/2004	1250	ACOG Webinar	2	152
<hr/>				
01/04/2005	1250	ACOG Webinar	2	2
04/26/2005	01	ACCME COURSE/MEETING	4	6
06/03/2005	01	ACCME COURSE/MEETING	7	13

06/04/2005	01	ACCME COURSE/MEETING	4	17
07/17/2005	1600	ACCME ETHICS/PROFESSIONAL RESP	2	19
11/01/2005	1250	ACOG Webinar	2	21
04/07/2006	01	ACCME COURSE/MEETING	16	37
05/13/2006	01	ACCME COURSE/MEETING	12	49

**REMINDER: THIS IS THE LAST YEAR TO REPORT COGNATES FOR CYCLE BEGINNING 2002**

Summary of Category I COGNATE Credits for Primary Cycle		AWARD EARNED FEB/2005	Summary of Category I COGNATE Credits for Secondary Cycle	
Reporting Years	Total COGNATE Credits		Reporting Years	Total COGNATE Credits
2002	38		2005	21
2003	66		2006	28
2004	48		2007	0
<b>Total COGNATE Credits This Cycle</b>		<b>152</b>	<b>Total COGNATE Credits This Cycle</b>	
			<b>49</b>	

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There's no guessing on late things

*to Julie Martinez*

**Dr. Jan Whitefield**

---

**From:** Martinez, Julie A., BME [Julie.Martinez@state.nm.us]  
**Sent:** Wednesday, August 23, 2006 8:51 AM  
**To:** [REDACTED]@gci.net  
**Subject:** RE: License Renewal Questions, Jan Whitefield, MD, NM license # 81-341, question regarding malpractice cases.

---

**From:** Martinez, Julie A., BME  
**Sent:** Wednesday, August 23, 2006 10:49 AM  
**To:** Martinez, Julie A., BME  
**Subject:** RE: License Renewal Questions, Jan Whitefield, MD, NM license # 81-341, question regarding malpractice cases.

Good morning Dr. Whitefield, you may submit the list and if I see any problems I will let you know.

---

**From:** Mohler, Barbara L., BME  
**Sent:** Wednesday, August 23, 2006 8:00 AM  
**To:** Martinez, Julie A., BME  
**Subject:** FW: License Renewal Questions, Jan Whitefield, MD, NM license # 81-341, question regarding malpractice cases.

Julie,

Please respond to Dr. Whitefield asap.

Thanks!

Barbara Mohler  
Licensing Manager  
New Mexico Medical Board  
2055 S. Pacheco St. Bldg. 400  
Santa Fe, NM 87505  
505-476-7226  
Fax 505-476-7233

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**From:** Jan Whitefield [mailto:[REDACTED]@gci.net]  
**Sent:** Tuesday, August 22, 2006 10:40 PM  
**To:** Mohler, Barbara L., BME  
**Subject:** RE: License Renewal Questions, Jan Whitefield, MD, NM license # 81-341, question regarding malpractice cases.

Barbara,

Thank you for your prompt reply. Much of my CME is done with direct confirmation of CME done through ACOG, the American College of Obstetrics and Gynecology. I can forward a copy of my most recent "report card" or "transcript" from ACOG, verifying my CME. Will this suffice? Otherwise I may have to work a little to get my original certificates for CME. Some is awarded directly through ACOG rather than issuing original certificates to the participant and then having them duplicated by the participant and sent to ACOG for registration. However, if necessary, I'm sure I can come up with original certifications from the appropriate institutions if necessary.

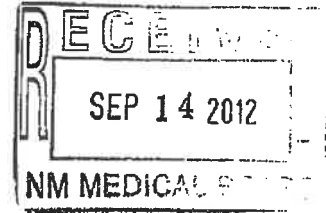
8/23/2006

## Whitefield, Jan E 81-341

<u>QUESTION ID</u>	<u>QUESTION TEXT</u>	<u>ANSWER</u>	<u>CREATE DATE</u>	<u>UPDATE DATE</u>
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	9/10/2012	9/10/2012
2.	Since your last renewal have you been denied professional liability insurance coverage?	N	9/10/2012	9/10/2012
3.	Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	9/10/2012	9/10/2012
4.	Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	9/10/2012	9/10/2012
5.	Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	9/10/2012	9/10/2012
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	9/10/2012	9/10/2012
7.	Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	9/10/2012	9/10/2012
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 whether you have had an appointment (a request which could result in either form)?	N	9/10/2012	9/10/2012
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 form)?	N	9/10/2012	9/10/2012
10.	a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, or not renewed, except for medical recertification?	N	9/10/2012	9/10/2012
	b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	9/10/2012	9/10/2012
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	9/10/2012	9/10/2012
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	9/10/2012	9/10/2012
	b. Are any currently held licenses pending investigation or being challenged?	N	9/10/2012	9/10/2012
13.	Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	9/10/2012	9/10/2012
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 any other restrictions?	N	9/10/2012	9/10/2012
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 details:	N	9/10/2012	9/10/2012
16.	Since your last renewal have you been reported to the National Practitioner Data Bank?	N	9/10/2012	9/10/2012
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	9/10/2012	9/10/2012
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 have?	N	9/10/2012	9/10/2012
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	9/10/2012	9/10/2012
20.	Are you ABMS (American Board of Medical Specialties) Board Certified?	Y	9/10/2012	9/10/2012
21.	If yes do you hold Lifetime Certification?	N	9/10/2012	9/10/2012
22.	If yes do you hold Time Limited Certification?	Y	9/10/2012	9/10/2012

Jan E Whitefield, MD

# Memo



**To:** New Mexico Medical Board  
**From:** Jan Whitefield, MD  
**Date:** 9/10/2012  
**Re:** CME for license re-application

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T Whom it may concern

Enclosed is a copy of my American Congress of Obstetrics and Gynecology transcript from 6/20/2008 through today. This tracks my CME.

2009 84 Category I credits

2010 103.25 Category I credits

2011 41 Category Credits.

I believe this satisfies the requirements for re-application.

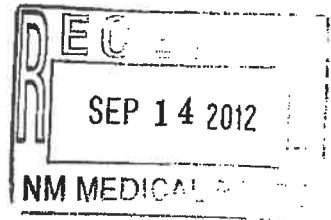
Thanks you for your help,

A handwritten signature in cursive script that reads "Jan Whitefield".

Jan E Whitefield, MD, PhD

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e-mail: [cognates@acog.org](mailto:cognates@acog.org)

ACOG ID Number: F 000270924I

Jan E. Whitefield MD



**Cognates Posted August 29, 2012**

Activity Date	Code	ACOG/ACCME Approved Category 1 Activity	COGNATE Credits	Cumulative Total by Cycle
06/20/2008	1240	ACOG JOINT SPONSORED MEETING	7.00	7.00
06/21/2008	1240	ACOG JOINT SPONSORED MEETING	7.00	14.00
06/22/2008	1240	ACOG JOINT SPONSORED MEETING	4.00	18.00
12/14/2008	01	ACCME COURSE/MEETING	16.75	34.75
12/31/2008	04	ABOG MOC Part 2 Article Review	35.00	69.75
03/21/2009	01	ACCME COURSE/MEETING	18.00	87.75
03/29/2009	11	ACCME SELF-INSTRUCT'L PROG	12.00	99.75
04/02/2009	4033	CU-V811-POLYCYSTIC OVARY SYNDROME	5.00	104.75
10/04/2009	1220	ACOG DISTRICT MEETING	14.00	118.75
12/31/2009	04	ABOG MOC Part 2 Article Review	<u>35.00</u>	153.75
03/02/2010	1240	ACOG JOINT SPONSORED MEETING	19.00	172.75
04/08/2010	04002	MOC-Endometrial Ablation for Abnormal Uterine Blee	3.00	175.75
04/09/2010	11	ACCME SELF-INSTRUCT'L PROG	15.00	190.75
09/05/2010	04422	MOC-Polycystic Ovary Syndrome	3.00	193.75
09/05/2010	04101	MOC-Augmentation of Labor	3.00	196.75
09/24/2010	01	ACCME COURSE/MEETING	6.25	203.00
09/25/2010	01	ACCME COURSE/MEETING	3.00	206.00
10/16/2010	1220	ACOG DISTRICT MEETING	16.00	222.00
12/31/2010	04	ABOG MOC Part 2 Article Review	35.00	257.00
<hr/>				
04/25/2011	04013	MOC-Tubal Sterilization	3.00	3.00
04/25/2011	04004	MOC-Evaluation of Perimenopausal Abnormal Uterine	3.00	6.00
04/25/2011	04214	MOC-Ultrasound and Postmenopausal Bleeding	3.00	9.00
12/31/2011	04	ABOG MOC Part 2 Article Review	35.00	44.00

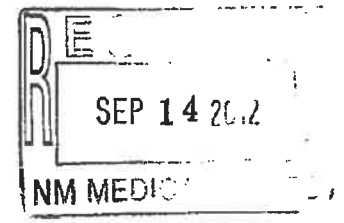
**This is the last year to report Cognates for Cycle beginning 2008**

<b>Summary of Category 1 COGNATE Credits</b>	<b>AWARD EARNED</b>	<b>Summary of Category 1 COGNATE Credits</b>
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<b>for Primary Cycle</b>		03/01/2011	<b>for Secondary Cycle</b>	
Reporting Years	Total COGNATE Credits		Reporting Years	Total COGNATE Credits
2008	69.75		2011	44.00
2009	84.00		2012	0.00
2010	103.25		2013	0.00
<b>Total COGNATE Credits This Cycle</b>		<b>257.00</b>	<b>Total COGNATE Credits This Cycle</b>	
			<b>44.00</b>	

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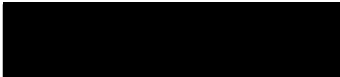
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<b>Total COGNATE Credits This Cycle</b>		<b>257.00</b>	<b>Total COGNATE Credits This Cycle</b>	
			<b>44.00</b>	