Medical Quality Assurance Commission
Physician Application Worksheet

Name: CHIAVARINI, ANDREA — Date of Birth: 10/22/1974 — REVIEW

Date Received: 6/9/10 — Temp Issued: — Number: — Closed: — INITIALS: [initials]

x	WSP Check	X	Fee	X	Photo	X	Data1-13		AIDS	X	Attest	X	SSN		EBHAR

Chronology — Complete — MISSING ____ to ____

FSMB	AMA	ECFMG	FBI REPORT
7/2/10	7/2/10		

Personal Data "Yes"s	Documentation Received	Malpractice Cases	Synopsis	Disposition
#10		1	X	X
		2		
		3		
		4		
		5		
		6		
		7		

Medical School Name: OR — Year of Degree: 2003 — 06/07/10 Transcripts — Translations

Examination Type: National Boards, FLEX, USMLE, State Exam, LMCC — 6/2/10

Post Graduate Training Programs

Received	Post Graduate Training Programs	review
6/15/10	U OF AZ 7/03-~~0~~ 6/07	✓

Received	Post Graduate Training Programs	review

					review	Received	
7/10	OR	✓	7/10	LEGACY MT HOOD	✓		
6/10	AZ	✓	7/10	PROVIDENCE PORTLAND	✓		

Approved: Signature: Catrina Murphy — Date: 7/8/10

Comments: Mal approved per Dr. Henz

500

PHYSICIAN & SURGEON

REVENUE SECTION

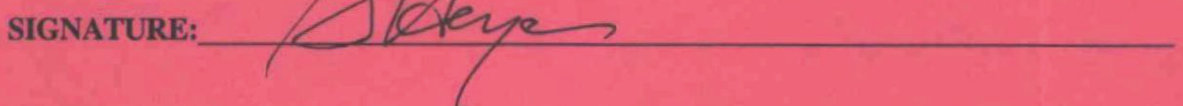
PRINT NAME Chiavarini, Andrea

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236

⑈0926⑈

0926-6/9/2010 7:34:42 AM-603 $500.00



MEDICAL QUALITY ASSURANCE COMMISSION

STAFF MEDICAL CONSULTANT REVIEW

APPLICANT Chivarini Andrea **DATE REVIEWED** 7/8/10

SUBMITTED BY: Catrina Murphy

MEDICAL CONSULTANT,
PLEASE REVIEW THE MALPRACTICE INFORMATION IN THE ATTACHED APPLICATION FILE.

APPROVED: ✓ **DISAPPROVED:** ________ **DATE:** 7-8-10

SIGNATURE: [signature]

COMMENTS: ________

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
A-L 360.236.2766
M-Z 360.236.2767

Background Check Processed
JUN 22 2010
NPDB/HIPDB
DEPARTMENT OF HEALTH

RECEIVED
JUN 09 2010
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Revenue 0252090000

Medical Practice License Application for MDs only

☐ National Boards ☐ Other State Exam ☐ LMCC (Must have been obtained after 1969)
☐ Flex Examination ☒ USMLE Examination

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.) ☐ Male ☒ Female

2 - DOH Licensee Social Security Number - RCW 42.56.350(1)

Name	First	Middle	Last
	ANDREA	HARRELL	CHIAVARINI

Birth date (mm/dd/yyyy)	Place of birth City	State	Country
10/22/1974	AURORA	CO	USA

Address: THE VANCOUVER CLINIC 700 NE 87TH AVE

City	State	Zip	County
VANCOUVER	WA	98664	CLARK

Country: USA

Phone	Fax	Cell
(503) 2065755	(360) 6041771	(1 - DOH Licensee Health Professional Home Ad...

Email address: harrell74@yahoo.com

Mailing address (if different from above)

City	State	Zip	County

Country

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

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

Will documents be received in another name? ☒ Yes ☐ No
If yes, list name(s): ANDREA LYNNE HARRELL

Medical Specialty

Medical school OREGON HEALTH & SCIENCE UNIVERSITY Year of graduation 2003
Medical specialty OBSTETRICS AND GYNECOLOGY

2. Personal Data Questions

	Yes	No
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.	☐	☒

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

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

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

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

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

	Yes	No
2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒

"Currently" means within the past two years.

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

	Yes	No
3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☒
4. Are you currently engaged in the illegal use of controlled substances?	☐	☒

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

	Yes	No
5. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?	☐	☒

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

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

2. Personal Data Questions (Cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction .... ☐ ☒

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

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? .... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .... ☐ ☒
   b. Diverted controlled substances or legend drugs? .... ☐ ☒
   c. Violated any drug law? .... ☐ ☒
   d. Prescribed controlled substances for yourself? .... ☐ ☒

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .... ☐ ☒

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .... ☐ ☒

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .... ☐ ☒

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .... ☒ ☐

11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? .... ☐ ☒

12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? .... ☐ ☒

13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application? .... ☐ ☒

14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? .... ☐ ☒

3. Medical Education and Experience

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

Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Diploma or degree obtained (Quote titles in original language and translate to English.)	Number of years attended	Dates granted	
			Start mm/yyyy	End mm/yyyy
Medical education (list all medical schools attended)				
OREGON HEALTH & SCIENCE UNIVERSITY	MD	4	09/1999	06/2003
Post graduate training (list all programs attended)				
UNIVERSITY OF ARIZONA OBSTETRICS AND GYNECOLOGY		4	07/2003	06/2007

4. Professional Experience

In chronological order list all professional experience received since graduation from medical school to the present. Exclude activities listed under other sections, identify any periods of time break of 30 days or more. If you need more space, attach a piece of paper.

Name and location of institution	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Nature of experience or specialty
MT HOOD WOMEN'S HEALTH, P.C. GRESHAM, OR	09/01/2007	present	Full-time private practice OB-GYN
DOWNTOWN WOMEN'S CENTER PORTLAND, OR	10/01/2007	present	Consultant OB-GYN - outpatient clinic

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

Excluding post-graduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

Name of hospital	Dates attended	
	Start date mm/dd/yyyy	End date mm/dd/yyyy
LEGACY MT. HOOD MEDICAL CENTER	09/01/2007	present
PROVIDENCE PORTLAND MEDICAL CENTER	09/01/2007	present

6. Licenses in Other States

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

State	Date license issued	License Number	Basis of License		Status of license	Any limitations on license
			Exam date passed	Endorsement		
OREGON	5/7/07	MD27441			ACTIVE	☒ No ☐ Yes
ARIZONA	7/1/06	76618			EXPIRED	☒ No ☐ Yes
ARIZONA	7/1/05	71823			EXPIRED	☒ No ☐ Yes
ARIZONA	7/1/04	68500			EXPIRED	☒ No ☐ Yes

7. AIDS Education and Training Attestation

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

Applicant's initials	Date
[initials]	6/1/10

8. Applicant's Photograph

Photo Here

Height 5'8"

Weight 140 lbs

Hair color Brown

Color of eyes Brown

Photo taken 6/4/2010

6. Licenses in Other States (continued)

ARIZONA Date issued: 7/1/03 License # 29826 Status: Expired

Limitations on license? No

9. Applicant's Attestation

I, ANDREA HARRELL CHIAVARINI, declare under penalty of perjury under the
(Print applicant name clearly)

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

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

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

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

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

Dated 6/1/10 at Portland, OR (city, state)

By: ______________________
Signature of applicant

Washington State Department of
Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
A-L 360.236.2766
M-Z 360.236.2767

MD

Professional Liability Action History

Applicant's name: ANDREA HARRELL CHIAVARINI Today's date: 6/2/10

Please submit a form for each past or current professional liability claim or lawsuit which has been filed against you. Photocopy this page as needed. Only a legible and signed narrative which addresses all of the following details will be accepted.

1. **Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. Please submit additional pages of narrative if necessary.**

   Date of occurrence: August 29, 2009 Details: Please see attached for details.

2. Date suit or claim was filed: 4/16/2010 Name and address of insurance carrier that handled the claim:
   The Doctors Company/Northwest Physicians
   PO Box 13400 Salem OR 97309
3. Your status in the legal action (primary defendant, codefendant, other): PRIMARY DEFENDANT
4. Current status of suit or other action: Please see attached for details
5. Date of settlement, judgment, or dismissal: n/a
6. If the case was settled out of court, or with a judgment, settlement amount paid on your behalf, please disclose the amount.

   You must enclose a copy of final disposition of case this includes dismissals. $ ______

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature ______ Date 6/2/10

DOH 657-099 (Rev. August 2009)

1. On August 29, 2009 I was present at and provided medical support for the birth of 3 - H... 3 - Healthcare I... baby. Pursuant to 3 - Healthcare Inform... prior request, I performed a tubal ligation surgical procedure on her after the delivery. 3 - Healthcare Infor... contends that during the procedure I nicked her bowel and did not repair the wound before terminating the procedure. 3 - Healthcare Info... further contends that, as a result, fecal matter leaked into her abdomen, causing infection, additional surgeries, and other forms of pain and suffering. I have not seen or spoken with 3 - Healthcare Infor... since November 2009. When I last had contact with her, I understood that she had recovered from the corrective surgery and was doing well.

Case caption: 3 - Healthcare Information Readi... v. *Andrea Chiavarini, M.D.*, Multnomah County (Oregon) Circuit Court Case No. 1004-05619

I have attached a copy of the Complaint.

4. This case is in its very early stages. The discovery process has begun but no depositions have been scheduled or taken by either side. Should you require additional information, please contact my attorney, Paul Silver, at 503-226-7677.

A TRUE COPY

1
2
3
4 IN THE CIRCUIT COURT OF THE STATE OF OREGON
5 FOR THE COUNY OF MULTNOMAH
6

CHRISTINA FARSTAD,	)
	) Case No. 1004 05619
Plaintiff,	)
	) COMPLAINT
vs.	) (Personal Injury – Non-Auto)
	) (Claim Not Subject to Mandatory
ANDREA CHIAVARINI, M.D.,	) Arbitration)
	) (Prayer Amount: $690,243.90)
Defendant.	)

12 COMES NOW Plaintiff, and for claim for relief against Defendant in medical
13 negligence causing personal injury to Plaintiff, complains and alleges as follows:
14
1.
15
16 That during all of the times herein mentioned, Andrea Chiavarini, M.D. was a
17 licensed medical doctor, physician and surgeon licensed to practice medicine in the State of
18 Oregon who held herself out as an expert or specialist in women's health/obstetrics and
19 gynecology.
20
2.
21
22 That prior to August 29, 2009, Plaintiff established a physician/patient relationship
23 with Defendant.
24
3.
25 That during the course and scope of that relationship on August 29, 2009, Defendant
26 performed the surgical procedure of tubal ligation and during the procedure Defendant

MERKEL & ASSOCIATES
Attorneys at Law
Crown Plaza
1500 S W First, Suite 1058
Portland, Oregon 97201
Telephone (503) 222-0058

1 caused Plaintiff's bowel to be cut and the wound was not repaired before the termination of
2 the surgical procedure and as a result, Plaintiff was injured in the manner hereinafter more
3 fully described.

4 4.

5 That at said time and place, Defendant was negligent and breached the standard of
6 care for physicians/surgeons in the community for the performance of said surgery in one or
7 more of the following particulars, to-wit:

8
9 (a) In cutting Plaintiff's bowel during the performance of the aforesaid surgery;
10 (b) In failing to repair the wound to Plaintiff's bowel before the surgery ended;
11 (c) In delaying care for the untreated wound caused during surgery; and
12 (d) In failing to promptly diagnose and treat the wound caused during surgery.

13 5.

14 That as the result of the negligence of Defendant as aforesaid, fecal material oozed
15 from Plaintiff's cut bowel into the abdominal cavity causing a generalized and systemic
16 infection, abdominal distention ascites, a pulmonary atelectasis, serosal tears, weakness,
17 fatigue, nausea, vomiting, and acute renal failure, and all of the aforesaid injuries have
18 caused Plaintiff to sustain pain and suffering, undergo multiple surgeries, and the injuries
19 have healed with permanent residuals, all to her noneconomic damage in a sum to be
20 determined by the jury not to exceed $500,000.
21
22 6.

23 That as the result of the negligence of Defendant as aforesaid, Plaintiff was required
24 to incur hospital and medical expenses to treat the injuries all to her economic damage in the
25 sum of $190,243.90 and Plaintiff will sustain additional medical expenses in the future.
26

MERKEL & ASSOCIATES
Attorneys at Law
Crown Plaza
1500 S.W. First, Suite 1050
Portland, Oregon 97201
Telephone (503) 222-0056

1 WHEREFORE, Plaintiff prays for Judgment against Defendant for a sum of
2 noneconomic damages in an amount to be determined by the jury not to exceed $500,000,
3 together with her economic damage in a sum to be determined by the jury not to exceed
4 $190,243.90, together with her costs and disbursements incurred herein.

5 MERKEL & ASSOCIATES

6

7 /s/ WILLARD E. MERKEL

By:______________________

8 Willard E. Merkel, OSB No. 79085
9 Telephone: (503) 222-0056
Facsimile: (503) 222-4461
10 E-mail: wmerkel@merkelassoc.com
Of Attorneys for Plaintiff

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MERKEL & ASSOCIATES
Attorneys at Law
Crown Plaza
1500 S.W. First, Suite 1050
Portland, Oregon 97201
Telephone (503) 222-0056

TYPE/PRINT IN PERMANENT BLACK INK.

OREGON DEPARTMENT OF HUMAN SERVICES

CENTER FOR HEALTH STATISTICS 136-

20030 1529
Local File Number

State File Number

APPLICATION, LICENSE, AND RECORD OF MARRIAGE

LOCAL OFFICIAL

COUNTY Multnomah

LICENSE EFFECTIVE ON OR AFTER 5-02-03

GROOM

1. GROOM'S NAME First: Clinton | Middle: Robert | Last: Chiavarini

2. BIRTHPLACE (State or Foreign Country): VIRGINIA
3. DATE OF BIRTH (Month, Day, Year): 10/12/71
4. AGE (18 or older, 17 with consent): 31

5. SEX: m
6. OCCUPATION: City Planner
7. PREVIOUS MARITAL STATUS (Single, Widowed, Divorced): Single

8a. FATHER'S NAME (First, Middle, Last): Robert Louis Chiavarini
8b. BIRTHPLACE (State or Foreign Country): Arkansas

9a. MOTHER'S NAME (First, Middle, Maiden Surname): Denise Jane Simon
9b. BIRTHPLACE (State or Foreign Country): Michigan

10. GROOM'S ADDRESS Street and Number: 2820 SE Main St | City or Town: Portland | County: Multnomah | State: OR | Zip: 97214

11. If affidavit is required as proof of age, the name and address of the affiant.
Name: Address:

CONSENT FORM WAIVER

BRIDE

12a. BRIDE'S NAME First: Andrea | Middle: Lynne | Last: Harrell

12b. MAIDEN SURNAME (If Different):
12c. PREVIOUS NAME (If Different):

13. BIRTHPLACE (State or Foreign Country): Colorado
14. DATE OF BIRTH (Month, Day, Year): 10, 22, 74
15. AGE (18 or older, 17 with consent): 28

16. SEX: F
17. OCCUPATION: Medical student
18. PREVIOUS MARITAL STATUS (Single, Widowed, Divorced): Single

19a. FATHER'S NAME (First Middle, Last): Norman Benton Harrell
19b. BIRTHPLACE (State or Foreign Country): South Carolina

20a. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Teresa McClain
20b. BIRTHPLACE (State or Foreign Country): Tennessee

21. BRIDE'S ADDRESS (Street and Number): 2820 SE Main St | City or Town: Portland | County: Multnomah | State: OR | Zip: 97214

22. If affidavit is required as proof of age, the name and address of the affiant.
Name: Address:

CONSENT FORM WAIVER

SIGNATURES

WE HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF OUR KNOWLEDGE AND BELIEF AND THAT WE ARE FREE TO MARRY UNDER THE LAWS OF THIS STATE.

23. GROOM'S LEGAL SIGNATURE: [signature]
24. BRIDE'S LEGAL SIGNATURE: Andrea Harrell

NEITHER YOU NOR YOUR SPOUSE IS THE PROPERTY OF THE OTHER. THE LAWS OF THE STATE OF OREGON AFFIRM YOUR RIGHT TO ENTER INTO MARRIAGE AND AT THE SAME TIME TO LIVE WITHIN THE MARRIAGE FREE FROM VIOLENCE AND ABUSE.

LICENSE TO MARRY

This License Authorizes the Marriage in this State of the Parties Named Above by Any Person Duly Authorized to Perform a Marriage Ceremony Under the Laws of the STATE OF OREGON.

25. LICENSE EXPIRES (Month, Day, Year): 7-02-03

26. DATE LICENSE ISSUED: 4-29-03
27. SIGNATURE OF ISSUING OFFICIAL: [signature]
28. TITLE OF ISSUING OFFICIAL: Deputy

THESE LINES – OFFICIAL USE ONLY

CEREMONY

29. I CERTIFY THAT THE ABOVE NAMED PERSONS WERE MARRIED ON - MONTH, DAY, YEAR: 6-08-03
30a. WHERE MARRIED - CITY, TOWN/LOCATON: TROUTDALE
30b. COUNTY: MULTNOMAH OREGO

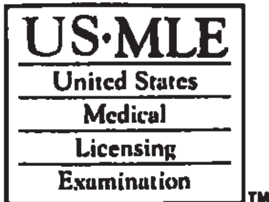
31a. SIGNATURE OF PERSON PERFORMING CEREMONY: [signature]
31b. NAME (Type/Print): BRENDAN THOMAS LOVE
31c. TITLE: REVEREND

31d. NAME/ADDRESS OF OFFICIANT'S AUTHORIZING RELIGIOUS CONGREGATION/ORGANIZATION: 601 3RD ST. MODESTO CA 95351 UNIVERSAL LIFE-CHURCH
31e. ADDRESS AND PHONE NUMBER OF PERSON PERFORMING CEREMONY: 112 EAST MURRAY AVENUE (919) 358-374[illegible] DURHAM, NORTH CAROLINA 27704

32. WITNESS NAME: John C. Sorensen
33. WITNESS NAME: Gregory J. Dotson

LOCAL OFFICIAL

34. SIGNATURE OF COUNTY CLERK OR DIRECTOR: Deborah K Huff
35. DATE FILED BY LOCAL OFFICIAL (Month, Day, Year): June 10, 2003



United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 – Telephone (817) 868-4041

Date : 06/02/2010

Recipient:

Washington Medical Quality Assurance Commission
ATTN: Maryella Jansen, Executive Director
243 Israel Road SE
Tumwater, WA 98501

Examinee ID#: 5-091-867-1
Date of Birth: 10/22/1974

Examinee: Chiavarini, Andrea
Alt Name(s): Chiavarini, Andrea Harrell
Harrell, Andrea Lynne

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	06/07/2001	Pass	222	182	90	75	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	12/17/2002	Pass	218	174	86	75	

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
ARIZONA	03/05/2007	Pass	222	184	91	75	

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

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

Interpretation of results
USMLE transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., "Incomplete." On those Step examinations for which numeric scores are reported, two different scales are used. The first is a three-digit score scale on which most scores fall between 140 and 280. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration. The second is a two-digit scale on which a score of 75 is the recommended minimum passing score. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points on the three-digit scale and 1 to 2 points on the two-digit scale.

STEP 2 CLINICAL SKILLS (CS)
The Clinical Skills (CS) component of Step 2 was introduced in 2004 and the USMLE transcript has been modified to reflect this change. The Step 2 examination that existed prior to the introduction of Step 2 CS continues to be administered as the Clinical Knowledge (CK) component of Step 2. The label "Step 2 CK" is used for this examination whether taken before or after the introduction of the Step 2 CS component.

Step 2 CS results are reported as pass or fail. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

Some individuals may be required to take and pass Step 2 CS prior to registering for Step 3. Transcript users can find information on eligibility requirements for all USMLE examinations in the *USMLE Bulletin of Information* and from periodic Step 2 CS updates, available at the USMLE website (www.usmle.org).
ANNOTATIONS APPEARING UNDER "COMMENTS"
Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed within this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"
Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"
The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record to the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
A-L 360.236.2766
M-Z 360.236.2767

MD

RECEIVED
JUN 17 2010
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

To: Hospital Administration (Excluding post-graduate training hospital privileges)

Hospital Name Providence Portland Medical Center

Address 4805 NE Glisan St

Portland OR 97213

RE: Verification and evaluation of privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information directly to the address shown below at your earliest convenience. All questions must be answered.

Applicant name Andrea H. Chiavarini (Print or type) Birth date 10/22/1974 (mm/dd/yyyy)

Signature of applicant [signature]

1. Andrea Chiavarini, MD has/had admitting or specialty privileges at this hospital from 9-1-2007 (mm/yyyy) to Present (mm/yyyy).
2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?
   ☐ Yes ☒ No If yes, please explain
3. Has the applicant ever been asked to resign? ☐ Yes ☒ No If yes, please explain
4. Did the applicant ever resign in lieu of or to avoid adverse action? ☐ Yes ☒ No
5. Has a report concerning the applicant ever sent to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank? ☐ Yes ☒ No

Return to: Medical Quality Assurance Commission P O Box 47866 Olympia, WA 98504-7866

L. Kaleen Stepnioski

Signature Henrietta M Pearson-Gomez

Title Credential COORD (Please type or print)

Hospital Providence Health & Services

Address 5050 NE Hoyt B48

Date 6/14/10

Telephone 503-215-0504

DOH 657-017 (Rev. August 2009)

THE WORD COPY APPEARS WHEN PHOTOCOPIED   A BLACK AND WHITE TRANSCRIPT IS NOT OFFICIAL

SSN: 2 - DOH Licensee Social Se...   Student No: U00011255   Date Issued: 03-JUN-2010

Record of: ANDREA HARRELL CHIAVARINI

Course Level: Medical
Matriculated: Fall 1999

Degree Awarded : Doctor of Medicine 04-JUN-2003
Major : Medicine

INSTITUTION CREDIT:

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	WKS
Academic Year 1999-2000						
FAMP	709E	Summer Observership	0.00	P	0.00	5
MSCI	611	Gross Anat/Imag/Emb	12.00	NH	24.00	16
MSCI	612	Cell Structure & Function	8.00	S	8.00	16
MSCI	711	Principles of Clinical Med I	4.00	NH	8.00	16
MSCI	613	System Processes & Homeostasys	9.00	S	9.00	12
MSCI	712	Principles of Clinical Med II	4.00	H	12.00	12
JCON	705A	Health Problem/Devel Countries	2.00	H	6.00	13
MSCI	614	Biological Basis of Disease	9.00	H	27.00	13
MSCI	713	Principles of Clinical Med III	4.00	H	12.00	13
		Total Earned Credits 52.00				
Academic Year 2000-2001						
CARD	791A	Electrocardiolography	1.00	P	0.00	16
MSCI	622	Circulation	8.00	NH	16.00	16
MSCI	624	Metabolism	5.00	NH	10.00	16
MSCI	714	Principles of Clinical Med IV	4.00	H	12.00	16
MSCI	621	Neuroscience & Behavior	8.00	NH	16.00	11
MSCI	623	Blood	4.00	H	12.00	11
MSCI	715	Principles of Clinical Med V	4.00	H	12.00	11
OBGY	705D	Reproductive Health Choices	2.00	P	0.00	11
JCON	717A	Transition to Clerkship	3.00	P	0.00	11
MSCI	626	Human Development	6.00	H	18.00	11
MSCI	716	Principles of Clinical Med VI	4.00	H	12.00	11
		Total Earned Credits 49.00				
Academic Year 2001-2002						
FAMP	720	Family Medicine	9.00	NH	18.00	6
IMED	720	General Internal Medicine I	9.00	S	9.00	6
JCON	720	Child Health I	9.00	H	27.00	6
OBGY	720	Obstetrics/Gynecology	9.00	NH	18.00	6
GMED	709C	Community Volunteer Med Clinic	0.00	AU	0.00	13
JCON	722	Primary Care	9.00	NH	18.00	6
SURG	720	Surgery I	9.00	H	27.00	6

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

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	WKS
Institution Information continued:						
GMED	709C	Community Volunteer Med Clinic	0.00	AU	0.00	12
IMED	721	Internal Medicine I	9.00	S	9.00	6
JCON	719	Continuity Curriculum/OSCE	2.00	P	0.00	51
		Total Earned Credits 65.00				
Academic Year 2002-2003						
GMED	709C	Community Volunteer Med Clinic	0.00	AU	0.00	14
OBGY	709A	Perinatology	6.00	H	18.00	4
SURG	721	Surgery II	6.00	NH	12.00	4
GMED	709C	Community Volunteer Med Clinic	0.00	AU	0.00	19
OBGY	709Z	Obstetrics/Gynecology - Away	6.00	P	0.00	4
PSYC	720	Psychiatry	9.00	NH	18.00	6
GMED	709C	Community Volunteer Med Clinic	0.00	AU	0.00	12
JCON	721	Child Health II	6.00	NH	12.00	4
NEUR	721	Neurology	6.00	H	18.00	4
JCON	718	Transition to Residency	3.00	P	0.00	1
OBGY	709E	Integrative Medicine Clinic	6.00	H	18.00	4
PATH	751A	Anatomic Pathology/Autopsy	6.00	H	18.00	4
		Total Earned Credits 54.00				

******************** TRANSCRIPT TOTALS ********************
Total Earned Credits 220.00
******************** END OF TRANSCRIPT ********************

RECEIVED
JUN 07 2010
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

OREGON HEALTH & SCIENCE UNIVERSITY

An official signature is white with a green background.

Cherie Honnell
Director of Financial Aid & Registrar

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OREGON HEALTH & SCIENCE UNIVERSITY

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

Under the provisions of Public Law 93-380 (as amended), the information contained in this document is not to be released to others without the written consent of the student named herein.

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

Accreditation
Oregon Health & Science University is accredited by the Northwest Commission on Colleges and Universities. In addition, all appropriate health care programs are accredited by specialized accrediting associations.

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

Course Numbering System

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

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

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

School of Dentistry (Prior to June 2006)

DMD courses:

610-619	Professional courses offered primarily in support of first year curriculum
620-629	Professional courses offered primarily in support of second year curriculum
630/730-639/739	Professional courses offered primarily in support of third year curriculum
640/740-649 749	Professional courses offered primarily in support of fourth year curriculum

Graduate courses:

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

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

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

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

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

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

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

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Portland, Oregon 97239-3098

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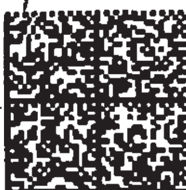

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M-Z 360.236.2767

RECEIVED
JUN 15 2010 MD
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

To: Post-Graduate Training Program Director

Facility Name University of Arizona Dept of OB-GYN

Address 1501 N Campbell Ave Tucson AZ 85724

RE: Verification/evaluation of training

I am applying for a license to practice as a physician in the state of Washington and before my application can be reviewed, a verification and evaluation of post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, directly to the address shown below. All questions must be answered.

Andrea H. Chiavarini — 10-22-1974

Applicant (Print or type) — Birth date

[signature]

Signature of applicant

1. 1. ______________________________

   was engaged in postgraduate training in our program OB/GYN Residency Program

   start July 1, 2003 end June 30, 2007

   (mm/yyyy) (mm/yyyy)

   in the field of OB/GYN

2. 2.At the time this individual was in training, was this program accredited through the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons, or the College of Family Physicians of Canada? ☒ Yes ☐ No If not, does this training program qualify this individual for board certification? ☐ Yes ☐ No

3. 3.Was the participant ever placed on probation, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☒ No If yes, please explain ______________________________

4. 4.Did this applicant successfully complete this training program?______________ ☒ Yes ☐ No

Return to:
Medical Quality Assurance Commission
P O Box 47866, Olympia, WA 98504-7866

Signature [signature]

Title Program Coordinator

Hospital University Medical Center

Address 1501 N. Campbell, Box 245078
Tucson, AZ 85746

Date 6/9/10

Telephone 520-626-6634

DOH 657-034 (Rev. August 2009)

Oregon

Theodore R. Kulongoski, Governor

Oregon Medical Board
620 Crown Plaza
1500 SW First Avenue
Portland, OR 97201-5826
(971) 673-2700
FAX (971) 673-2670

Verification of Licensure

June 01, 2010

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

Licensee:	Chiavarini, Andrea Harrell, Dr.
Date of Birth:	10/22/1974
Gender:	Female
Business Phone:	
Mailing Address:	24850 SE Stark Ste 200 Gresham, OR 97030
Basis of Licensure:	USMLE
School:	Oregon Hlth & Science Univ
School Location:	Portland, OR, United States
Graduation Date:	06/04/2003
*Disciplinary Standing:	Unrestricted
License Number:	MD27441
Status:	Active
Status Limitations:	
Date Issued:	05/07/2007
Expiration Date:	12/31/2011
License Type:	MD License
Specialty:	Obstetrics and Gynecology
Dispensing Physician:	No

** Please read explanation below*

**** IMPORTANT - PLEASE READ***

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

Arizona Medical Board
9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2707
Website: www.azmd.gov • E-Mail: questions@azmd.gov

RECEIVED
JUN 07 2010
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

License Verification

Date:	June 3, 2010			
State Board:	Arizona Medical Board			
Licensee:	Andrea Harrell Chiavarini, MD			
Type of License:	Resident			
License Number:	29826	68500	71823	76618
Start Date:	07/01/2003	07/01/2004	07/01/2005	07/01/2006
End Date:	06/30/2004	06/30/2005	06/30/2006	06/30/2007

Unless otherwise indicated, the State of Arizona has not disciplined this licensee.

Carol Parrish

Carol Parrish
Executive Assistant
Arizona Medical Board
(480) 551-2791

Washington State Department of Health

Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
A-L 360.236.2766
M-Z 360.236.2767

MD

RECEIVED
JUN 10 2010
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

To: Hospital Administration (Excluding post-graduate training hospital privileges)

Hospital Name Legacy Mt. Hood Medical Center

Address 24800 SE Stark St
Gresham OR 97030

RE: Verification and evaluation of privileges

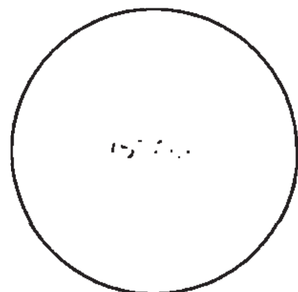
I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information directly to the address shown below at your earliest convenience. **All questions must be answered.**

Applicant name Andrea H. Chiavarini (Print or type) Birth date 10/22/1974 (mm/dd/yyyy)

Signature of applicant [signature]

1. Andrea Chiavarini, MD has/had admitting or specialty privileges at this hospital from 8/16/2007 (mm/yyyy) to present (mm/yyyy).
2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?
   ☐ Yes ☒ No If yes, please explain ______
3. Has the applicant ever been asked to resign? ☐ Yes ☒ No If yes, please explain ______
4. Did the applicant ever resign in lieu of or to avoid adverse action? ☐ Yes ☒ No
5. Has a report concerning the applicant ever sent to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank? ☐ Yes ☒ No

Return to: Medical Quality Assurance Commission P O Box 47866 Olympia, WA 98504-7866



Signature Ann Moeschke, CPMSM

Title Medical Staff Coordinator (Please type or print)

Hospital Legacy Mt Hood Med Ctr

Address 24800 SE Stark St.
Gresham, OR 97030

Date 6/8/10

Telephone (503) 674-1561

DOH 657-017 (Rev. August 2009)

NO HOSPITAL SEAL

		OREGON PENNSYLVANIA SOUTH CAROLINA TENNESSEE TEXAS UTAH VIRGINIA			
10	BENTZ, CHARLES	02/26/1962	050010	1988	22459023
		LICENSE HISTORY State Board OREGON			
3	BERNHART, KRISTIN	05/24/1974	039100	2005	22458943
		LICENSE HISTORY State Board WASHINGTON			
5	BIRNBAUM, MATTHEW	05/25/1974	034010	2006	22458948
		LICENSE HISTORY State Board WASHINGTON			
11	BIYYAM, DEEPA	10/31/1978	495450	2002	22459032
		LICENSE HISTORY State Board WASHINGTON			
1	BRENDEL, WILLIAM	12/09/1981	044050	2008	22458938
		LICENSE HISTORY State Board WASHINGTON			
2	BRUNEAU, PIERRE	02/05/1966	019030	1995	22458940
		LICENSE HISTORY State Board CALIFORNIA NEW YORK WASHINGTON			
9	BURDICK, MICHAEL	01/06/1978	047020	2005	22459019
		LICENSE HISTORY State Board WASHINGTON			
8	BYRD, DANIEL	04/26/1968	044080	2003	22458958
		LICENSE HISTORY State Board OREGON			
13	CHANG, TAMMY	10/04/1980	023030	2007	22459037
		LICENSE HISTORY State Board MICHIGAN			
17	CHIAVARINI, ANDREA	10/22/1974	038010	2003	22459054
		LICENSE HISTORY State Board OREGON			
15	COOK, JONATHAN	09/25/1974	010020	2006	22459042

AMA Physician Profile

Name and Mailing Address:

ANDREA LYNNE HARRELL MD
24850 SE STARK ST STE 200
GRESHAM OR 97030-8320

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: 1-503-491-9444

Birthdate: 10/22/1974
Birthplace: DENVER, CO UNITED STATES OF AMERICA

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY
Secondary Specialty: UNSPECIFIED

****Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.***

AMA membership: NON MEMBER

——— All Information from this Point Forward is Provided by the Primary Source ———

Current and/or Historical Medical School:

OR HLTH SCI UNIV SCH OF MED, PORTLAND OR 97201
Degree Awarded: Yes
Degree Year: 2003

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AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: UNIV OF AZ COLL OF MED **State:** ARIZONA
Specialty : OBSTETRICS & GYNECOLOGY 07/2003 - 06/2007 (VERIFIED)

Note: **If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.**

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
OREGON	MD	05/07/2007	12/31/2011	ACTIVE	UNLIMITED	04/19/2010

Note: **When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.**

Current and/or Historical NPI Information:

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1255536405	06/18/2007	NOT RPTD	NOT RPTD	NOT RPTD	05/03/2010

ECFMG Certfication:

Applicant Number:

Note: **The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.**

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Federal Drug Enforcement Administration:

** Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
None	Reported		

Address:

Note: **Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.**

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate Type: GENERAL

Duration	Effective	Expiration	Occurrence	Last Reported
TIME LIMITED	12/11/2009	12/31/2015	INITIAL	06/03/2010

Note: **For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.**

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Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

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Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site (http://www.ama-assn.org/go/amaprofiles) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60654
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

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