Mihelich, Joe D (DOH)

From: Mihelich, Joe D (DOH)
Sent: Tuesday, June 24, 2014 8:43 AM
To: 'jess.guh@swedish.org'
Subject: full license issued MD.MD.60467205 expires 9/14/15
Attachments: Address change.mht; New license holder.pdf

You now have a full license.

Joe Mihelich
Health Services Consultant 1
Medical Quality Assurance Commission
PO BOX 47866
Olympia WA 98504
360-236-2767 phone
360-236-2795 Fax
Website: www.doh.wa.gov/Medical
Email: joe.mihelich@doh.wa.gov

Medical Quality Assurance Commission
Physician Application Worksheet

Name JESSICA GUH DOB 9/14/1984

Date Received 4/17/14 Temp Issued [ ] Number [ ] Closed [ ]

X ✓	WSP Check	x	Fee	x	Photo	x	Data1-14	x	AIDS	x	Attes	X	SSN	X

Chronology [ ]

MISSING

4/17/14 ✓	14/17/14 ✓	[ ]	[ ]
FSMB	AMA	ECFMG	FBI

Personal Data "Yes"s	Documentation Received

Malpractice Cases	Synopsis	Disposition
1		
2		
3		
4		
5		
6		
7		

Medical School

Name MICHIGAN Year of Degree 2012 5/29/12 ✓ Transcripts [ ] Translations

Examination Type [ ] National [ ] FLEX [ ] USMLE [ ] State Exam [ ] LMCC 5 13 Scores Received

Post Graduate Training Programs

Received	Training Programs
6/17	SWEDISH CHERRY HILL RES 7/12-PRESENT ✓

Post Graduate Training Programs

Received	Training Programs

Received	State

Received	Hospital verification

Received	

Approved Dawn Thompson Signature Date 6/20/14

Comments:

PHYSICIAN & SURGEON

Health 166-

REVENUE SECTION

PRINT NAME Guh, Jessica

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236

#2445#

$166.00

2445-4/17/2014 7:37:54 AM-601

Washington State Department of Health

See Limited File ESS

Background Check Processed
APR 16 2014
Background Check Stamp Here
NCSC, III DB/WSP
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Date Received Stamp Here
APR 17 2014
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

Name	First	Middle	Last
	JESSICA	WENDY	GUH

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country
09/14/1984	NEW LONDON	CT	USA

Address: 1201 BOYLSTON AVE APT 411

City	State	Zip Code	County
SEATTLE	WA	98101	KING

Country: USA

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
1 - DOH Licensee Health Professional Home Add...		

Email address: JESS.GUH@SWEDISH.ORG

Mailing address if different from above address of record: 550 16TH AVE SUITE 400

City	State	Zip Code	County
SEATTLE	WA	98122	KING

Country: USA

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

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

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

Medical Specialty

Medical school: UNIVERSITY OF MICHIGAN Year of graduation: 2012

Medical specialty: FAMILY MEDICINE

00288612

4/18/14

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, intellectual disabilities, 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.

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.

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.

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?	☐	☒
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☒

3. Medical Education and Experience

Provide a date 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)				
UNIVERSITY OF MICHIGAN	MD	4	08/2008	06/2012
Post graduate training (list all programs attended)				
~~SWEDISH CHERRY HILL FAMILY MEDICINE~~		3		

4. Professional Experience

In date 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
SWEDISH CHERRY HILL FAMILY MEDICINE	07/01/2012	CURRENT	FAMILY MEDICINE RESIDENCY

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

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 date 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		
WA		ML60288612			CURRENT	☐ No ☒ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four 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
JG	4-1-14

8. Applicant's Photograph

Photo Here

Height 5'4"

Weight 135

Hair color BLACK

Color of eyes BROWN

Signature _____

Date of Photo 3/31/14

9. Applicant's Attestation

I, JESSICA GUH , 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 03/31/2014 at SEATTLE, WA
(mm/dd/yyyy) (city, state)

By: _____
(Signature of applicant)

Admitted to MEDICAL SCHOOL | Matriculated: 2008 | THE UNIVERSITY OF MICHIGAN | Control #: M1148127-01TM01

Standard Program | ANN ARBOR | Academic Record of:

Medical School Dates of Attendance:
Year:08-09 08/04/2008 05/31/2009
Year:09-10 08/17/2009 04/30/2010
Year:10-11 05/05/2010 05/01/2011
Year:11-12 05/09/2011 04/27/2012

Degree:
Doctor of Medicine
Date conferred:
11-MAY-2012

Guh,Jessica

ID Number: 67700129

University Registrar

Course Title	Credit Hours	Grade
01 Fall 2008 08/04/2008 - 12/21/2008		
02 Patients & Pop 500	4.0	S**
03 Clinical Foundations 500	(L11)	Y
04 Soc&Behav Iss in Med	(L12)	Y
05 Cells & Tissues 500	4.0	S**
06 Musculoskeletal 513	4.0	S**
07 Cardio/Resp 504	5.0	S**
08 Renal 506	2.0	S**
09 Winter 2009 01/05/2009 - 05/31/2009		
10 GI/Liver 508	3.0	S**
11 Clinical Foundations 501	7.0	S**
12 Soc&Behav Iss in Med	4.0	S**
13 Endocrine/Repro 510	3.0	S**
14 Immunology 501	2.0	S**
15 CNS/Head & Neck 509	4.0	S**
16 ID/Microbiology 500	7.0	S**
17 Growth & Development 500	2.0	S**
18 Promoted To 2nd Year 05/30/2009		
19 Fall 2009 08/17/2009 - 12/20/2009		
20 Cardiovascular 604	4.0	S**
21 Soc&Behav Iss in Med	(L31)	Y
22 Clinical Foundations	(L32)	Y
23 Respiratory 605	3.0	S**
24 Renal 606	4.0	S**
25 Psychiatry 614	1.0	S**
26 Neurosciences 609	5.0	S**
27 Musculoskeletal 613	2.0	S**
28 Dermatology 612	1.0	S**
29 Winter 2010 01/04/2010 - 04/30/2010		
30 Hematology/Oncology 603	5.0	S**
31 Soc&Behav Iss in Med	3.0	S**
32 Clinical Foundations 601	5.0	S**
33 01/2010 Comp Clinical Assessment Exam		S**
34 Gastrointestinal 608	6.0	S**
35 Endocrine 610	3.0	S**
36 Reproduction 611	4.0	S**
37 04/2010 U.S. Med Licensing Exam Step 1		S
38 Promoted To Clinical Phase 04/30/2010		
39 Internal Medicine 05/10/2010-08/01/2010	12.0	H
40 Seminars in Medicine 05/10/2010-05/01/2011	0.0	S**
41 Psychiatry 08/02/2010-09/12/2010	6.0	HP
42 Obstetrics/Gynecology 09/13/2010-10/24/2010	6.0	HP
43 Surgery 10/25/2010-11/21/2010	(L44)	
44 Surgery 11/22/2010-12/19/2010	8.0	HP
45 Family Medicine 01/10/2011-02/06/2011	4.0	HP
46 Neurology 02/07/2011-03/06/2011	4.0	H
47 Pediatrics 03/07/2011-05/01/2011	8.0	H
48 Vacation 05/09/2011-06/05/2011		
49 05/2011 Comp Clinical Assessment Exam		S**
50 Geriatrics Sub-I 06/06/2011-07/03/2011	4.0	H
51 Pediatrics, Developmental 07/04/2011-07/31/2011	4.0	H
52 Anesthesiology, CVICU 08/01/2011-08/28/2011	4.0	HP
53 08/2011 U.S. Med Lic Exam Step 2 CK		S
54 E:Medicine, General 08/29/2011-09/25/2011	4.0	H
55 Emergency Medicine 09/26/2011-10/23/2011	4.0	H
56 10/2011 U.S. Med Lic Exam Step 2 CS		S
57 Medical Therapeutics 10/24/2011-11/20/2011	4.0	HP
58 Vacation 11/21/2011-12/18/2011		
59 Vacation 01/09/2012-02/05/2012		
60 Family Planning 02/06/2012-03/04/2012	4.0	H
61 Sociocultural Medicine 03/05/2012-04/01/2012	4.0	S**
62 Fordson Outreach 04/02/2012-04/27/2012	4.0	HP**
DEGREE REQUIREMENTS COMPLETED 04/27/2012		

RECEIVED
MAY 29 2012
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Key: H = Honors, HP = High Pass, P = Pass, F = Fail
S = Satisfactory, U = Unsatisfactory, I = Incomplete, Y = Continuing Course, NC = No Credit
W = Official Withdrawal*, W/P = Withdrawal Passing, W/X = Withdrawal Extenuating Circumstances*, W/F = Withdrawal Failing
AP = Advanced Placement*, FM = Fail Marginal*
E = Senior Clerkship, (L) = Refer to line indicated
* Applies prior to 7/93 only
** Graded S/F/I or P/F/I
Effective: 9/95

Date issued: 23-MAY-2012

TAMPER PROOF SEAL ● TAMPER PROOF SEAL ● TAMPER PROOF SEAL

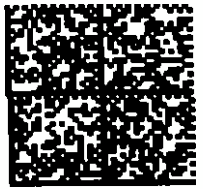
UNIVERSITY OF MICHIGAN
OFFICE OF THE REGISTRAR

TRANSCRIPT & CERTIFICATION DEPT.

1210 LSA BUILDING
500 S. STATE ST.
ANN ARBOR, MI 48109-1382

UNIVERSITY OF MICHIGAN
OFFICE OF THE REGISTRAR
TRANSCRIPT & CERTIFICATION DEPT.
1210 LSA BUILDING
500 S. STATE ST.
ANN ARBOR, MI 48109-1382

RETURN SERVICE REQUESTED



Hasler

016H26515550

$00.450

05/24/2012

Mailed From 48109

US POSTAGE

M1148127-01TM01NN

Joe Mihelich

PO BOX 47866

Olympia, WA 98504

US·MLE
United States
Medical
Licensing
Examination

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4000

Date : 05/13/2014

Recipient:

Washington Medical Quality Assurance Commission
ATTN: MD Credentialing Unit
PO Box 47866
Olympia, WA 98504-7866

Examinee: Guh, Jessica Wendy
Alt Name(s):

Examinee ID#: 5-237-557-3
Date of Birth: 09/14/1984

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	04/26/2010	Pass	238	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	08/03/2011	Pass	267	(189)	

Clinical Skills (CS)[a]

	Test Date	Pass/Fail	Total	MP	Comments
	10/05/2011	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
WASHINGTON	02/03/2014	Pass	238	(190)	

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

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
A-L 360-236-2765
M-Z 360-236-2767

RECEIVED
JUN 17 2014
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

MD

To: Post Graduate Training Program Director

Facility name SWEDISH CHERRY HILL FAMILY MEDICINE

Address 550 16TH AVE SUITE 400 SEATTLE WA 98122

RE: Verification/evaluation of training

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the 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 above. All questions must be answered.

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
JESSICA GUH	09/14/1984

Signature of applicant

1. JESSICA GUH (Applicant Name (Print or type)) is or was engaged in postgraduate training in our program SWEDISH FAMILY MEDICINE (CHERRY HILL)
from Beginning date (month & year) 07/2012 to Ending date (month & year) 06/2015
in the field of FAMILY MEDICINE

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 no, does this program qualify the applicant to become board certified? ☐ Yes ☐ No

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

4. Did this applicant successfully complete this training program? ☐ Yes ☐ No
☐ In process OR ☒ expected date of completion 06/2015

Return to address listed above. Signature
(Please type or print)

(SEAL)

Title Program Director

Address 550 16th Ave Suite 100
Seattle, WA 98122

Date 6/16/2014 Phone 206-320-2233

DOH 657-034 February 2014

AMA Physician Profile

Name and Mailing Address
JESSICA WENDY GUH MD
APT 411
1201 BOYLSTON AVE
SEATTLE WA 98101-2875

Primary Office Address
550 16TH AVE
SEATTLE WA 98122-5699

Phone UNKNOWN

Birth date 09/14/1984

Physician's major professional activity HOSPITAL BASED RESIDENTS - ALL YEARS

Self-designated practice specialty FAMILY MEDICINE (primary)

Self-designated practice specialties (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 verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration date	Deactivation date	Reactivation date	Replacement number	Last reported date
1851652135	06/04/2012	NOT RPTD	NOT RPTD	NOT RPTD	03/31/2014

Current and/or historical medical school

UNIV OF MI MED SCH, ANN ARBOR MI 48109
Degree Awarded: Yes
Degree Year: 2012

AMA AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: SWEDISH MED CTR
Sponsoring State: WASHINGTON
Program name: SWEDISH MEDICAL CENTER/CHERRY HILL PROGRAM
Specialty: FAMILY MEDICINE
Dates: 06/2012 06/2015 (Verified)

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
WASHINGTON	MD	05/30/2012	07/31/2014	ACTIVE	LIMITED	04/01/2014

ECFMG Certfication

Applicant Number:

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 online at https://cvsonline2.ecfmg.org/

AMA AMERICAN MEDICAL ASSOCIATION

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration date	Last Reported date	Address:
XXXXXX660	22N 33N 4 5	09/30/2015	04/07/2014	550 16th Ave, Seattle, WA 98122-5699

Only the last three characters of active DEA numbers are displayed

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

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 Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

AMA AMERICAN MEDICAL ASSOCIATION

Certifying board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate type:

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date

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.

Action notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

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.

AMA
AMERICAN
MEDICAL
ASSOCIATION

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. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log onto our website (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 questions. Or you can mark the issues on a copy of the profile and mail or fax to:

American Medical Association
Division of Database Products
Attn: Physician Products Portfolio
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Fax: (312) 464-5900

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

April 17, 2014

Attn: Maryella E. Jansen
Washington Medical Quality Assurance Commission
Maryella E. Jansen
PO Box 47866
Olympia, WA 98504-7866

Re: Board Action Query Dated: April 17, 2014
Your Reference Number:
FSMB Batch Number: BQ2428563

The following is a final report of the search results from the Board Action Data Bank as of April 17, 2014 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 17, 2014

Item	Name	DOB	School	Yr/Grad	Request ID
1	GUH, JESSICA	09/14/1984	023030	2012	27275562

LICENSE HISTORY
State Board
WASHINGTON ✓

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

Washington State Department of Health

APR 23 2012
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Revenue 0252140000

Limited Physician & Surgeons License Application

☒ Resident Physician ☐ Teaching/Research ☐ Institutional
☐ Fellowship (2 year limit) ☐ County/City Health Department

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

2 - DOH Licensee Social Se...

Name ☐ Mr. ☒ Ms. First JESSICA Middle WENDY Last GUH

Birth date (MM/DD/YYYY) 09/19/1984

Place of Birth: City NEW LONDON State CT Country USA

Address SWEDISH FAMILY MEDICINE CHERRY HILL 550 -16TH AVENUE #100 City SEATTLE

State WA Zip 98122 County KING

Phone # 1 - DOH Licensee Health Professional ... Fax # Cell # 1 - DOH Licensee Health Pro...

Email Address: GUHSTER@GMAIL.COM

Have you ever been known under any other name(s)? If yes, list name(s): N/A

Will documents be received in another name? If yes, list name(s): N/A

Institution or Training Program Information (Required)

Institution/Program Name SWEDISH FAMILY MEDICINE CHERRY HILL

Institution/Program Mailing Address 550 16TH AVENUE #100

City SEATTLE State WA

Zip 98122 County KING

Medical Specialty

Medical school UNIVERSITY OF MICHIGAN Year of Graduation 2012

Medical Specialty FAMILY MEDICINE

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, intellectual disabilities, 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.

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.

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.

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.

Mihelich, Joe D (DOH)

From: Mihelich, Joe D (DOH)
Sent: Monday, May 21, 2012 11:50 AM
To: 'guhster@gmail.com'
Subject: MISSING ITEM

May 21, 2012

Dear Dr. Guh,

This is to acknowledge receipt of your application to obtain a limited license in the state of Washington.

Your application and fee of $400.00 was received on April 23, 2012 .

MISSING ITEMS

TRANSCRIPTS WITH DEGREE POSTED OR LETTER STATING THAT YOU WILL BE GRADUATING OR HAVE GRADUATED

If you have any further questions or need additional information, please feel free to call me at (360) 236-2771 email me at joe.mihelich@doh.wa.gov , or write to me at Department of Health, Medical Quality Assurance Commission, P O Box 47866, Olympia, WA 98504-7866.

Sincerely,

Joe Mihelich
Customer Service Specialist II
Medical Quality Assurance Commission
PO BOX 47866
Olympia WA 98504
360-236-2771
360-236-2795 Fax
Website: www.doh.wa.gov/hsqa/mqac
Email: joe.mihelich@doh.wa.gov

Admitted to MEDICAL SCHOOL | Matriculated: 2008

Standard Program

Medical School Dates of Attendance:
Year:08-09 08/04/2008 05/31/2009
Year:09-10 08/17/2009 04/30/2010
Year:10-11 05/05/2010 05/01/2011
Year:11-12 05/09/2011 04/27/2012

THE UNIVERSITY OF MICHIGAN

ANN ARBOR

Degree:
Doctor of Medicine
Date conferred:

Control #: N1136773-01TM01

Academic Record of:

Guh,Jessica

ID Number: 67700129

University Registrar

Course Title	Credit Hours	Grade
01 Fall 2008 08/04/2008 - 12/21/2008		
02 Patients & Pop 500	4.0	S**
03 Clinical Foundations 500	(L11)	Y
04 Soc&Behav Iss in Med	(L12)	Y
05 Cells & Tissues 500	4.0	S**
06 Musculoskeletal 513	4.0	S**
07 Cardio/Resp 504	5.0	S**
08 Renal 506	2.0	S**
09 Winter 2009 01/05/2009 - 05/31/2009		
10 GI/Liver 508	3.0	S**
11 Clinical Foundations 501	7.0	S**
12 Soc&Behav Iss in Med	4.0	S**
13 Endocrine/Repro 510	3.0	S**
14 Immunology 501	2.0	S**
15 CNS/Head & Neck 509	4.0	S**
16 ID/Microbiology 500	7.0	S**
17 Growth & Development 500	2.0	S**
18 Promoted To 2nd Year 05/30/2009		
19 Fall 2009 08/17/2009 - 12/20/2009		
20 Cardiovascular 604	4.0	S**
21 Soc&Behav Iss in Med	(L31)	Y
22 Clinical Foundations	(L32)	Y
23 Respiratory 605	3.0	S**
24 Renal 606	4.0	S**
25 Psychiatry 614	1.0	S**
26 Neurosciences 609	5.0	S**
27 Musculoskeletal 613	2.0	S**
28 Dermatology 612	1.0	S**
29 Winter 2010 01/04/2010 - 04/30/2010		
30 Hematology/Oncology 603	5.0	S**
31 Soc&Behav Iss in Med	3.0	S**
32 Clinical Foundations 601	5.0	S**
33 01/2010 Comp Clinical Assessment Exam		S**
34 Gastrointestinal 608	6.0	S**
35 Endocrine 610	3.0	S**
36 Reproduction 611	4.0	S**
37 04/2010 U.S. Med Licensing Exam Step 1		S
38 Promoted To Clinical Phase 04/30/2010		
39 Internal Medicine 05/10/2010-08/01/2010	12.0	H
40 Seminars in Medicine 05/10/2010-05/01/2011	0.0	S**
41 Psychiatry 08/02/2010-09/12/2010	6.0	HP
42 Obstetrics/Gynecology 09/13/2010-10/24/2010	6.0	HP
43 Surgery 10/25/2010-11/21/2010	(L44)	
44 Surgery 11/22/2010-12/19/2010	8.0	HP
45 Family Medicine 01/10/2011-02/06/2011	4.0	HP
46 Neurology 02/07/2011-03/06/2011	4.0	H
47 Pediatrics 03/07/2011-05/01/2011	8.0	H
48 Vacation 05/09/2011-06/05/2011		
49 05/2011 Comp Clinical Assessment Exam		S**
50 Geriatrics Sub-I 06/06/2011-07/03/2011	4.0	H
51 Pediatrics, Developmental 07/04/2011-07/31/2011	4.0	H
52 Anesthesiology, CVICU 08/01/2011-08/28/2011	4.0	HP
53 08/2011 U.S. Med Lic Exam Step 2 CK		S
54 E:Medicine, General 08/29/2011-09/25/2011	4.0	H
55 Emergency Medicine 09/26/2011-10/23/2011	4.0	H
56 Medical Therapeutics 10/24/2011-11/20/2011	4.0	HP
57 Vacation 11/21/2011-12/18/2011		
58 Vacation 01/09/2012-02/05/2012		
59 Family Planning 02/06/2012-03/04/2012	4.0	H
60 Sociocultural Medicine 03/05/2012-04/01/2012	4.0	
61 Fordson Outreach 04/02/2012-04/27/2012	4.0	

Key: H = Honors, HP = High Pass, P = Pass, F = Fail, S = Satisfactory, U = Unsatisfactory, I = Incomplete, Y = Continuing Course, NC = No Credit, W = Official Withdrawal*, W/P = Withdrawal Passing, W/X = Withdrawal Extenuating Circumstances*, W/F = Withdrawal Failing, AP = Advanced Placement*, FM = Fail Marginal*, E = Senior Clerkship, (L) = Refer to line indicated

* Applies prior to 7/93 only
** Graded S/F/I or P/F/I

Effective: 9/95

Date issued: 05-APR-2012

APR 10 2017

DEPARTMENT OF HEALTH
MEDICAL COMMISSION

TAMPER PROOF SEAL ● TAMPER PROOF SEAL ● TAMPER PROOF SEAL

UNIVERSITY OF MICHIGAN
OFFICE OF THE REGISTRAR
TRANSCRIPT & CERTIFICATION DEPT.
1210 LSA BUILDING
500 S. STATE ST.
ANN ARBOR, MI 48109-1382

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OFFICE OF THE REGISTRAR
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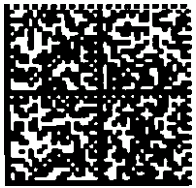
RETURN SERVICE REQUESTED



Hasler

016H26515550
$00.45⁰
04/05/2012
Mailed From 48109
US POSTAGE

M1136773-01TM01NN

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

98504$7866

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

May 04, 2012

Attn: Maryella E. Jansen
Washington Medical Quality Assurance Commission
Maryella E. Jansen
PO Box 47866
Olympia, WA 98504-7866

Re: Board Action Query Dated: May 04, 2012
Your Reference Number:
FSMB Batch Number: BQ2072030

The following is a report of the search results from the Board Action Data Bank as of May 04, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 04, 2012

Item	Name	DOB	School	Yr/Grad	Request ID
4	GUH, JESSICA	09/14/1984	023030	2012	25225573
		LICENSE HISTORY State Board No License Information Available			
3	KARP, JESSICA	02/22/1984	033020	2012	25225572
		LICENSE HISTORY State Board No License Information Available			
2	KHATTAR, ANUJ	09/14/1985	038010	2012	25225570
		LICENSE HISTORY State Board No License Information Available			
1	MJELDE, GRETCHEN	06/26/1986	048010	2012	25225569
		LICENSE HISTORY State Board No License Information Available			

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

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Washington State Department of Health

LMT

Medical Quality Assurance Commission

Resident Physician Limited License

This certifies the appointment of the following individual who is being recommended for a limited license in Washington State.

Name of Resident Physician* : JESSICA GUH

Name of training program/specialty: SWEDISH FAMILY MEDICINE, CHERRY HILL

Name of sponsoring institution: SWEDISH MEDICAL CENTER

Beginning date 6/19/2012
mm/dd/yyyy

(Signature) Director of Program

Is this an ACGME Program? ..... Yes ☒ No ☐

* Resident physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.055 and is serving a period of post graduate clinical medical training sponsored by a college or university in this state or by a hospital accredited by this state. The term shall include individuals designated as intern or medical fellow.

Note: The issuance of a limited license does not allow the individual to engage in the practice of medicine outside the supervision of the post-graduate clinical medical training program.

Return to:

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

9. Applicant's Attestation

I, JESSICA GUH , 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 3/25/12 at ANN ARBOR, MI (city, state)

By: _____
Signature of applicant

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		
N/A						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

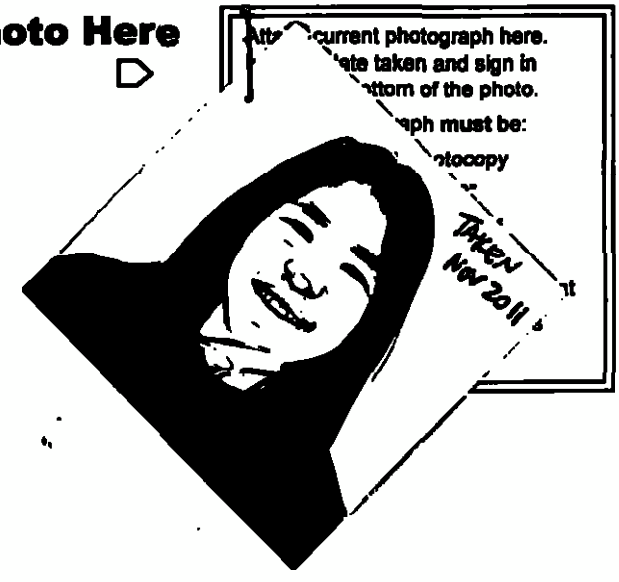
7. AIDS Education and Training Attestation

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
JG	3/25/12

8. Applicant's Photograph

Photo Here



Height 5'4"

Weight 130 LBS

Hair color BLACK

Color of eyes BROWN

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)				
UNIVERSITY OF MICHIGAN	MD	4	07/2008	05/2012
Post graduate training (list all programs attended)				
N/A				

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
N/A			

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
N/A		

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? N/A	☐	☐
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?	☐	☒

8

400

Health

LIMITED PHYSICIAN

REVENUE SECTION

PRINT NAME Guh, Jessica

1F 0252140000 00335

"2218"

2218-4/23/2012 7:40:16 AM-601 $400.00

APPROVED

Medical Quality Assurance Commission
Limited License Application Worksheet

Name GUH, JESSICA Date of Birth 9/14/1984

Date Received 4/23/12

5/9/12	WSP Check	x	Fee	x	Photo	x	Data1-13	x	AIDS	x	Attest	x	SSN	x	SS# letter

Chronology	Missing:			
x		to		
		to		
Complete		to		

☐ Residency ☐ Institution

☐ Fellowship ☐ City/County

☐ Teaching/Research

5/4/12	FSMB ✓
N/A	AMA

Personal Data "Yes"s	Documentation Received

Malpractice Cases	Synopsis	Disposition
1		
2		
3		
4		

Medical School

Name UNIV OF MICHIGAN Year of Degree 2012 5/9/12 Transcripts ✓ ☐ Translations

Post Graduate Training Programs	Received

Post Graduate Training Programs	Received

Received	State Licensure

Received	Hospital Privileges

Received	Program/Employment Verification
x	SWEDISH FAMILY MEDICINE 6/19/12 ✓

Approved Dawn Thompson 5/30/12

Signature Date

Comments:

Credential View Screen [update]

Jessica Wendy Guh
Address:
○ Public ◉ Mail

[change mail address]
Jessica Wendy Guh
Swedish Family Medcline Cherry Hill
550 16th Ave #100
Seattle, WA 98122

ID	1030389
Warnings	
SSN/FEIN	2 - DOH Licensee Soc...
Contact Standing	Living
Contact Type	INDIVIDUAL
Birth Date	09/14/1984
Public File	YES
Mailing List	
US Citizen	
Email:	guhster@gmail.com

Contact
Audit
Enforcement
Cont. Edu
Documents
Owned By/Ke
Exams
Experience
Notes
Schools
Librarian
Other State L
Online Inforr

Comments:

Physician And Surgeon Residency License [update] [form letter]

Credential #	**MDRE.ML.60288612**
Application Date	04/23/2012
Effective Date	
Expiration Date	
First Issuance Date	
Last Date Of Contact	05/04/2012

Credential Status	**PENDING (05/07/2012)**
Status Reason	INITIAL APPLICATION IN PROCESS
Amount Due	**$400.00**
Date Last Activity	5/7/2012 11:38:20 AM
Last Updated by	Mihelich, Joe D
Certificate Sent Date	

RECEIVED
MAY 09 2012
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Audit
Documents
Verification
Workflow
Key Mgmt
Fees
Notes
Print Docs
Comp. Audit
Renewal
License Status

Comments:
- **Supervises**
- **User Defined License Data**
- **Workflow**

User Definable License Data [update]

Field	Value
Method of Licensure	**EDUCATION/TRAINING**
Cash Receipt Sequence Number	**02218**
Cash Receipt Date	**20120423**
Cash Receipt Batch Number	**0601**

Background Check Processed
MAY 08 2012
WSP
Department of Health
CSO/ Credentialing Unit

Nimon, Lori (DOH)

From: Nimon, Lori (DOH)
Sent: Tuesday, April 29, 2014 1:56 PM
To: 'jess.guh@swedish.org'
Subject: Pending MD License 60467205

April 29, 2014

Dear Dr. Guh,

This is to acknowledge receipt of your fee and application for your physician and Surgeon licensure in the state of Washington. At this time these are the items we still need before we can fully review your application file.

MISSING ITEMS

Need USMLE scores (these can be ordered at www.fsmb.org)
Need postgraduate training verification from Swedish Cherry Hill 7/12 to Present

You can email me at anytime for a current status update on your application file.

*If you are using the FCVS packet with the Federation of State Medical Boards (FSMB) you will need to contact FSMB to determine when this packet will be released to us. The FCVS packet will verify medical school transcripts, exam scores, and postgraduate training.

Please note: while this information was contained in the application packet you had been sent and is stipulated in Washington Administrative Code (WAC) 246-12-020(3), let me reiterate that upon approval, your initial license will be issued *only* to your next birthday after the approval date – unless your birthday falls within 90 days of approval, in which case it will expire on your second birthday following approval.

If you have any further questions or need additional information, email me at lori.nimon@doh.wa.gov or write to me at the address listed below.

Thanks,

Lori Nimon
Health Services Consultant 1
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA. 98504
lori.nimon@doh.wa.gov
(360) 236-2765 ☎
(360) 236-2795 🖷

Application File_1166314_pdf-r.pdf redacted on: 1/17/2019 14:07

Redaction Summary (5 redactions)

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2 Privilege / Exemption reasons used:

1 -- "DOH Licensee Health Professional Home Address and/or Home Phone Number - RCW 42.56.350(2)" (3 instances)
2 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (2 instances)

Redacted pages:

Page 5, DOH Licensee Health Professional Home Address and/or Home Phone Number - RCW 42.56.350(2), 1 instance
Page 23, DOH Licensee Health Professional Home Address and/or Home Phone Number - RCW 42.56.350(2), 2 instances
Page 23, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 40, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance