

telnet (GothomCity)

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          AAAAAA   SSSSSS   IIIIIIIIII
          AAAAAAA   SSS  SSS   IIIIIIIIII
          AAAAAAAA   SSS   SSS    III
MEDICAL BOARD      ASSESSMENT SYSTEMS, INC.      03-10-04
bje1303             REAL SYSTEM      V2.5.74      03:14:21 PM
INDIVIDUAL NAME    (JR,SR,III)      REFERENCE # MC00015507
      LAST DUNN      SOC SEC NUM 1-DOH Licensee Social ...
      FIRST TAYLOR
      MIDDLE M
RESIDENCE INFORMATION
POB 1281
KOTZEBUE AK 99752

PHONE: (   )   -   COUNTY:   51
      (   )   -   LGL ST:

NOTES

+-----+
| CURRENT STATUS: U   EXPIRATION DATE: 03-10-2004   FIRST ISSUE DATE: 03-10-2004 |
| RENEWAL STATUS:    LAST ACTIVE DATE:   -   -   LAST RENEWAL DATE: 03-10-2004 |
| COMPLAINTS O/C:   0/ 0   AUTHORITY:                                     |
+-----+
1GO BACK  2NAM&ADDR 3EDUCATE 4LIC FUNC 5INVESTG 6          7OTHR DAT 8EXTD NOT
```

```

+--ADDITIONAL INFORMATION-----+
|                                |
|   SEX M =   MARRIED Y =   |
|                                |
|   OTHER NAME   |
| CORP. OFFICER   |
| TRUST ACCOUNT   |
|                                |
|   BIRTH PLACE MISSOULA MT   |
|   DATE 03-09-1968   |
|                                |
|   SCHOOL CODE 054.04   |
|   CE UNITS 0.00 REQD BY - -   |
+-----+
```

## DEFICIENCY LETTER LOG SHEET

| ITEM                 | Calendar Date                    | Julian Date |
|----------------------|----------------------------------|-------------|
| Application Received | <del>F 10 2004</del>             |             |
| Deficiency Letter 1  | MAR 10 2004                      |             |
| Deficiency Letter 2  | <del>MAR 10 2004</del><br>APR 30 |             |
| Deficiency Letter 3  |                                  |             |
| Deficiency Letter 4  |                                  |             |
| Deficiency Letter 5  |                                  |             |
| Deficiency Letter 6  |                                  |             |
| Deficiency Letter 7  |                                  |             |
| Deficiency Letter 8  |                                  |             |
| Deficiency Letter 9  |                                  |             |
| Deficiency Letter 10 |                                  |             |
| Deficiency Letter 11 |                                  |             |
| Deficiency Letter 12 |                                  |             |
| Deficiency Letter 13 |                                  |             |
| Deficiency Letter 14 |                                  |             |
| Deficiency Letter 15 |                                  |             |
| Deficiency Letter 16 |                                  |             |
| Deficiency Letter 17 |                                  |             |
| Deficiency Letter 18 |                                  |             |
| Deficiency Letter 19 |                                  |             |
| Deficiency Letter 20 |                                  |             |



# Medical Quality Assurance Commission Physician Application Worksheet

Name DUNN TAYLOR Date of Birth 03/09/1968

Date Received 03/03/2004 Candidate Number \_\_\_\_\_ License Number \_\_\_\_\_

☒ Background Check ☒ Fee ☒ Photo ☒ Data 1-13 ☒ AIDS ☒ Attest ☒ SSN

Chronology ☐ Missing: \_\_\_\_\_  
☐ Complete \_\_\_\_\_  
☐ Temp Permit Issued Number: \_\_\_\_\_  
☒ 2/26/04 FSMB ☒ 3/5/04 AMA ☐ ECFMG ☐ Archive File

| Personal Data "Yes"s | Documentation Received | Malpractice Cases | Synopsis                            | Disposition |
|----------------------|------------------------|-------------------|-------------------------------------|-------------|
| #9                   |                        | 1                 | <input checked="" type="checkbox"/> |             |
|                      |                        | 2                 |                                     |             |
|                      |                        | 3                 |                                     |             |
|                      |                        | 4                 |                                     |             |

Medical School U OF WASHINGTON School Code 1999 ☒ U.S. ☐ Canadian ☐ International  
 Name U OF WASHINGTON Year of Degree 1999 ☒ 2/26/04 ☐ Translations

Examination Type ☐ National Boards ☐ FLEX ☒ USMLE ☐ State Exam ☐ LMCC ☒ 5/12

|  |                   |  |  |  |  |
|--|-------------------|--|--|--|--|
|  | VENTURA 7/99-6/02 |  |  |  |  |
|  |                   |  |  |  |  |
|  |                   |  |  |  |  |

|  |    |  |         |          |
|--|----|--|---------|----------|
|  | CA |  | 3/1/04  | VENTURA  |
|  | AK |  | 2/23/04 | MANILLAQ |
|  |    |  |         |          |
|  |    |  |         |          |
|  |    |  |         |          |
|  |    |  |         |          |
|  |    |  |         |          |

Signature Delia A. Lopez

Date 5/21/04

Comments: See: Malpractice case approval by CA Dept

325



PHYSICIAN & SURGEON

REVENUE SECTION

PRINT NAME Dunn, T

RETURN THIS PORTION  
WITH CHECK & APPLICATION

LF 0252050000 00236

MEDICAL QUALITY ASSURANCE COMMISSION

STAFF MEDICAL CONSULTANT REVIEW

APPLICANT NAME: Dunn, Taylor DATE REVIEWED 5/24/04

SUBMITTED BY: H. Brey

MEDICAL CONSULTANT,

PLEASE REVIEW THE MALPRACTICE INFORMATION IN THE ATTACHED APPLICATION FILE.

APPROVED: ✓ DISAPPROVED: \_\_\_\_\_ DATE: 5-21-04

SIGNATURE: [Signature]

COMMENTS: \_\_\_\_\_



Washington State Department of  
**Health**  
Health Professions Quality Assurance Division  
P.O. Box 1099  
Olympia, WA 98507-1099  
(360) 236-4785  
(360) 236-4784

Background Check Processed

MAR 3 2004

|   |                     |
|---|---------------------|
| DEPARTMENT OF HEALTH<br>INVESTIGATION SECTION | FOR OFFICE USE ONLY |
| ISSUANCE DATE                                 | UNIT                |
| LICENSE #                                     | 43708               |

LICENSE #

## APPLICATION FOR LICENSE TO PRACTICE MEDICINE APPLICABLE FOR MD'S ONLY

- ☐ National Boards ☐ Other State Exam ☐ LMCC (must have been obtained after 1969)  
☐ FLEX Examination ☒ USMLE Examination

**Please Type or Print Clearly** – Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

### 1. DEMOGRAPHIC INFORMATION

|                  |               |        |                |
|------------------|---------------|--------|----------------|
| APPLICANT'S NAME | LAST          | FIRST  | MIDDLE INITIAL |
|                  | DUNN          | TAYLOR | M              |
| ADDRESS          | P.O. Box 1281 |        |                |
| CITY             | STATE         | ZIP    | COUNTY         |
| KOTZEBUE         | AK            | 99752  | USA            |

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

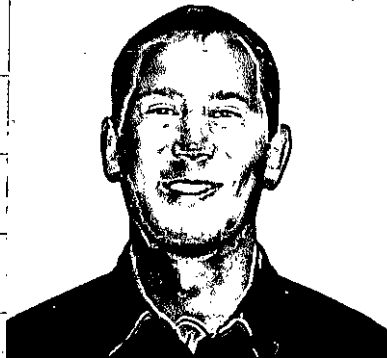
|  |   |                       |
|--|---|-----------------------|
| TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.) | SOCIAL SECURITY NUMBER                          |                       |
| (907) 442-7494   | 1 - DOH Licensee Social Security Number - RC... |                       |
| GENDER   | BIRTHDATE (MO/DAY/YEAR)                         | PLACE OF BIRTH        |
| <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male               | 3/9/68  | MISSOULA, MONTANA USA |

Have you previously applied for a Washington State license or limited license? ☐ Yes ☒ No

Have you ever been known under any other name(s)? ☐ Yes ☒ No

If yes, list name(s):

|                              |                    |
|------------------------------|--------------------|
| HEIGHT                       | WEIGHT             |
| 5'11"                        | 160#               |
| EYE COLOR                    | HAIR COLOR         |
| GREEN                        | BROWN              |
| MEDICAL SCHOOL               | YEAR OF GRADUATION |
| UNIVERSITY OF WASHINGTON SOM | '99                |
| MEDICAL SPECIALTY            |                    |
| FAMILY PRACTICE              |                    |



## 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 explain.

☐ ☒

**"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.

- 1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).
- 1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.

☐ ☒

**"Currently"** means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

**"Chemical substances"** includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?

☐ ☒

4. Are you currently engaged in the illegal use of controlled substances?

☐ ☒

**"Currently"** means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

**"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

**If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.**

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

☐ ☒

a. the use or distribution of controlled substances or legend drugs?

☐ ☒

b. a charge of a sex offense?

☐ ☒

c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)

6. Have you ever been found in any civil, administrative or criminal proceedings 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, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?

☐ ☒

b. committed any act involving moral turpitude, dishonesty or corruption?

☐ ☒

c. violated any state or federal law or rule regulating the practice of a health care professional?

☐ ☒

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", explain 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, or have you ever surrendered such credential to avoid or in connection with action by such authority?

☒ ☐

9. 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?

See Attachment.



| <b>2. PERSONAL DATA QUESTIONS (continued)</b>   |                             |                                     |      |   |
|---|-----------------------------|-------------------------------------|------|---|
|   | YES                         | NO                                  |      |   |
| 10. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?   | <input type="checkbox"/>    | <input checked="" type="checkbox"/> |      |   |
| 11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?   | <input type="checkbox"/>    | <input checked="" type="checkbox"/> |      |   |
| 12. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?   | <input type="checkbox"/>    | <input checked="" type="checkbox"/> |      |   |
| 13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?   | <input type="checkbox"/>    | <input checked="" type="checkbox"/> |      |   |
| <b>3. EDUCATION AND EXPERIENCE</b><br>Provide a chronological listing of your educational preparation and post-graduate training.<br>(Attach additional 8 1/2 x 11 sheets if necessary.)  |                             |                                     |      |   |
| Schools Attended<br>(Location if other than U.S., quote names of schools in original language and translate to English.)  | Number of<br>Years Attended | Dates Attended                      |      | Diploma or Degree Obtained<br>(Quote titles in original language and translate to English.) |
| From (mo/yr)  | To (mo/yr)                  |                                     |      |   |
| Medical Education (List all Medical Schools Attended)   |                             |                                     |      |   |
| UNIVERSITY OF WASHINGTON SOM  | 4                           | 9/95                                | 6/99 | M.D.  |
| Post-Graduate Training (List all Programs Attended)   |                             |                                     |      |   |
|   |                             |                                     |      |   |
|   |                             |                                     |      |   |
| <b>4. PROFESSIONAL EXPERIENCE</b><br>In chronological order list all professional experience received since graduation from medical school to the present.<br>(Exclude activities listed under other sections, identify any periods of time break of 30 days or more.)<br>(Attach additional 8 1/2 X 11 sheets if necessary.) |                             |                                     |      |   |
| Nature of Experience or Practice  | Dates of Experience         |                                     |      |   |
|   | From (mo/yr)                | To (mo/yr)                          |      |   |
| VENTURA FAMILY PRACTICE RESIDENCY, CA   | 7/99                        | 6/02                                |      |   |
| (VACATION & RELOCATION TO ALASKA)   | 7/02                        | 8/02                                |      |   |
| MANILLAQ HEALTH CENTER, KOTZEBUE, AK  | 8/02                        | PRESENT.                            |      |   |
|   |                             |                                     |      |   |
| <b>5. HOSPITAL PRIVILEGES</b><br>List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. (Attach additional 8 1/2 X 11 sheets if necessary.)   |                             |                                     |      |   |
| NAME OF HOSPITAL<br>(For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)   | DATES                       |                                     |      |   |
|   | Beginning (mo/yr)           | Ending (mo/yr)                      |      |   |
| VENTURA COUNTY MEDICAL CENTER, VENTURA, CA  | (Approx) 2/02               | (Approx) 8/03                       |      |   |
| MANILLAQ HEALTH CENTER, KOTZEBUE, AK  | 8/02                        | PRESENT                             |      |   |
|   |                             |                                     |      |   |
|   |                             |                                     |      |   |

**6. LICENSES IN OTHER STATES**

List all licenses to practice medicine in any state, Canadian province or other country. (Include whether active or inactive.)

| State, Country or Province | Date License Issued | License Number | Basis of Licensure        |             | Status of License Active or Inactive | Any Limitations On License |
|----------------------------|---------------------|----------------|---------------------------|-------------|--------------------------------------|----------------------------|
|                            |                     |                | Examination (Date Passed) | Endorsement |                                      |                            |
| CALIFORNIA                 | 10/5/00             | A73208         |                           | ✓           | Active                               | NONE                       |
| ALASKA                     | 9/12/02 12/6/02     | 4865           |                           | ✓           | Active                               | NONE                       |
|                            |                     |                |                           |             |                                      |                            |
|                            |                     |                |                           |             |                                      |                            |

**7. FIFTH PATHWAY (Foreign Trained Applicants only)** (Attach additional 8 1/2 X 11 sheets if necessary.)

| Name and Location of Fifth Pathway Program | Name and Location of Hospital | Dates Attended    |                |
|--|-------------------------------|-------------------|----------------|
|  |                               | Beginning (mo/yr) | Ending (mo/yr) |
|  |                               |                   |                |

**8. AIDS AFFIDAVIT**

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS. I understand I must maintain records documenting said education, for two (2) years and be prepared to submit those records to the Department of Health if requested. (WAC 246-919-380)

Taylor M. Dunn MD

APPLICANT'S SIGNATURE

2/15/04

DATE

**9. APPLICANT'S ATTESTATION**

I, TAYLOR M. DUNN, certify that I am the person described and identified in this application, that I have read 18.130.170 RCW and 18.130.180 RCW, of the Uniform Disciplinary Act, and that I have answered all questions in the application truthfully and completely and the documentation provided in support of the application is, to the best of my knowledge, accurate. I understand that the Department may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Commission any information, files or records required by the Commission for its evaluation of my professional, ethical and physical qualifications for licensure in the State of Washington. I understand the Commission may request a physical and mental evaluation to determine my fitness for practice.

Taylor M. Dunn MD

APPLICANT'S SIGNATURE

2/15/04

DATE

**Official Use Only**

**Washington State Records  
Center**

HPOA  
RECEIVED

MAR 03 2004

Application for Full Medical License in State of Washington

Question # 9 Clarification

To Whom It May Concern:

On January 4, 2002, I was one of the doctors named in a lawsuit. I was a resident physician at the time. While assisting on a bilateral tubal ligation in July of the previous year, the patient suffered an operative complication requiring overnight hospitalization and a blood transfusion. She went home the next day and had a full recovery. My name was dropped from the suit.

Details available through Ventura County Medical Center, Ventura, CA (805) 652-6000.

Sincerely,

A handwritten signature in cursive script that reads "Taylor Dunn M.D.". The signature is written in black ink and is positioned above the printed name.

Taylor Dunn, M.D.

RECEIVED

MAY 12 2004

DEPARTMENT OF HEALTH  
HEALTH PROFESSIONS 5

5/7/04.

Hello -

As to our telephone communication  
yesterday, enclosed is documentation verifying  
dismissal / clarifying Question #9 in my application.

If more info is needed on anything else is  
incomplete in my application, please contact me  
as soon as possible.

Thanks.

Sincerely, Taylor Dunn MD

TAYLOR DUNN

(907) 442-7499 W

442-2825 H.

tdunn@manilaq.org

Application for Full Medical License in State of Washington

Question # 9 Clarification

To Whom It May Concern:

On January 4, 2002, I was one of the doctors named in a lawsuit. I was a resident physician at the time. While assisting on a bilateral tubal ligation in July of the previous year, the patient suffered an operative complication requiring overnight hospitalization and a blood transfusion. She went home the next day and had a full recovery. My name was dropped from the suit.

Details available through Ventura County Medical Center, Ventura, CA (805) ~~652-6000~~.

654-3127

Sincerely,

*Taylor Dunn M.D.*

Taylor Dunn, M.D.

Enclosed is a copy of  
the dismissal for  
verification.

*Dr.*

**BAUER, HARRIS, CLINKENBEARD & RAMSEY, LLP**

ATTORNEYS AT LAW

P. O. BOX 21007

SANTA BARBARA, CALIFORNIA 93121-1007

TELEPHONE (805) 965-0043 FAX (805) 965-8894

hspackman@bhclaw.com

MARVIN A. BAUER  
ROBERT F. HARRIS  
WILLIAM CLINKENBEARD  
PATRICIA K. RAMSEY  
HUGH S. SPACKMAN  
MAUREEN E. CLARK  
LESLEY E. CUNNINGHAM

STREET ADDRESS:  
925 DE LA VINA STREET

SUITE 100  
SANTA BARBARA, CALIFORNIA 93101

June 4, 2002

**PERSONAL & CONFIDENTIAL**

Taylor Dunn, M.D.  
c/o Ventura County Medical Center  
3291 Loma Vista Road  
Ventura, CA 93003

Re: ***Herrera v. COUNTY OF VENTURA, VENTURA COUNTY MEDICAL  
CENTER, et al.***  
**VCSC Case Number: CIV 208701**

Dear Dr. Dunn:

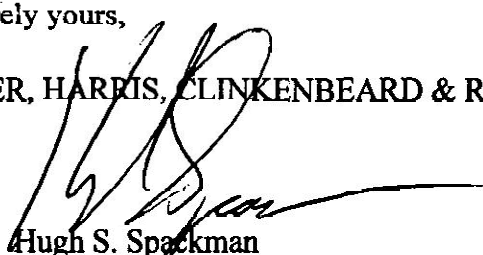
Enclosed please find for your records, a conformed copy of the Request for Dismissal regarding the above-referenced matter. Should you have any questions, please do not hesitate to contact me.

Thank you for your professional courtesy.

Sincerely yours,

BAUER, HARRIS, CLINKENBEARD & RAMSEY, LLP

By

  
Hugh S. Spackman

:bvtd  
Encls.  
\\Bhcrsv\server\hss\Herrera\Letters\Dunn2-Ltr.wpd

|   |   |
|---|---|
| ATTORNEY OR PARTY WITHOUT ATTORNEY (Name and Address):<br><b>Hugh S. Spackman #150204</b> (805) 965-0043<br><b>BAUER, HARRIS, CLINKENBEARD &amp; RAMSEY, LLP</b><br>925 De La Vina Street<br>Suite 100<br>Santa Barbara, CA 93101   | <b>FOR COURT USE ONLY</b><br>VENTURA<br>SUPERIOR COURT<br><b>FILED</b><br><br><b>MAY 29 2002</b><br><br><b>MICHAEL D. PLANET</b><br>Executive Officer and Clerk<br>_____ Deputy |
| ATTORNEY FOR (Name): <b>Defendants, COUNTY OF VENTURA, et al</b>  |   |
| Insert name of court and name of judicial district and branch court, if any:<br><b>VENTURA COUNTY SUPERIOR COURT</b><br><b>VENTURA</b>  |   |
| PLAINTIFF/PETITIONER: <b>KIMBERLY L. HERRERA &amp; ROBERT HERRERA</b><br>DEFENDANT/RESPONDENT: <b>COUNTY OF VENTURA, VENTURA COUNTY MEDICAL CENTER, FRED KELLEY, M.D., et al.</b>   |   |
| <b>REQUEST FOR DISMISSAL</b><br><input checked="" type="checkbox"/> <b>Personal Injury, Property Damage, or Wrongful Death</b><br><input type="checkbox"/> <b>Motor Vehicle</b> <input type="checkbox"/> <b>Other</b><br><input type="checkbox"/> <b>Family Law</b><br><input type="checkbox"/> <b>Eminent Domain</b><br><input type="checkbox"/> <b>Other (specify):</b> |   |
| CASE NUMBER:<br><b>CIV 208701</b>   |   |

— A conformed copy will not be returned by the clerk unless a method of return is provided with the document. —

**1. TO THE CLERK: Please dismiss this action as follows:**

- a. (1) ☐ With prejudice      (2) ☐ Without prejudice
- b. (1) ☒ Complaint      (2) ☐ Petition  
 (3) ☐ Cross-complaint filed by (name):  
 (4) ☐ Cross-complaint filed by (name):  
 (5) ☐ Entire action of all parties and all causes of action  
 (6) ☒ Other (specify):\* **AS TO DEFENDANT, TAYLOR DUNN, M.D. ONLY**

on (date):  
on (date):

Date: April 27 2002

**BENJAMIN FOGEL**

(TYPE OR PRINT NAME OF ☒ ATTORNEY ☐ PARTY WITHOUT ATTORNEY)

**BENJAMIN FOGEL, INC.**

(SIGNATURE)

Attorney or party without attorney for:

\* If dismissal requested is of specified parties only, of specified causes of action only, or of specified cross-complaints only, so state and identify the parties, causes of action, or cross-complaints to be dismissed.

☒ Plaintiff/Petitioner      ☐ Defendant/Respondent  
☐ Cross-complainant

**2. TO THE CLERK: Consent to the above dismissal is hereby given.\*\***

Date:

(TYPE OR PRINT NAME OF ☐ ATTORNEY ☐ PARTY WITHOUT ATTORNEY)

(SIGNATURE)

Attorney or party without attorney for:

\*\* If a cross-complaint - or Response (Family Law) seeking affirmative relief - is on file, the attorney for cross-complainant (respondent) must sign this consent if required by Code of Civil Procedure section 581(l) or (l).

☐ Plaintiff/Petitioner      ☐ Defendant/Respondent  
☐ Cross-complainant

(To be completed by clerk)

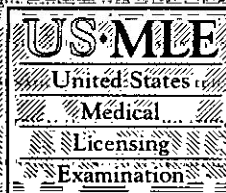
3. ☐ Dismissal entered as requested on (date):  
 4. ☐ Dismissal entered on (date): as to only (name):  
 5. ☐ Dismissal not entered as requested for the following reasons (specify):

6. ☐ a. Attorney or party without attorney notified on (date):  
     b. Attorney or party without attorney not notified. Filing party failed to provide  
         ☐ a copy to conform      ☐ means to return conformed copy

Date: **MAY 29 2002**

**MICHAEL D. PLANET**

Clerk, by **MARISELA SOTO**, Deputy



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

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 03/10/2004

Washington Medical Quality Assurance Commission

ATTN: Doron Maniecc, Exec Director

310 Isreal Road SE

Tumwater, WA 98501

Examinee: Dunn, Taylor Michael

USMLE ID#: 5-029-284-6

DOB: 03/09/1968

Alt Name(s):

Results for all 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. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

| STEP1       | Test Date | Pass/<br>Fail | Three-Digit |           | Two-Digit |           |
|-------------|-----------|---------------|-------------|-----------|-----------|-----------|
|             |           |               | Score       | (Passing) | Score     | (Passing) |
|             | 6/10/1997 | PASS          | 213         | (176)     | 85        | (75)      |
| STEP2       | Test Date | Pass/<br>Fail | Three-Digit |           | Two-Digit |           |
|             |           |               | Score       | (Passing) | Score     | (Passing) |
|             | 8/25/1998 | PASS          | 219         | (170)     | 86        | (75)      |
| STEP3       | Test Date | Pass/<br>Fail | Three-Digit |           | Two-Digit |           |
|             |           |               | Score       | (Passing) | Score     | (Passing) |
| State Board | 2/17/2000 | PASS          | 225         | (177)     | 89        | (75)      |
| CALIFORNIA  |           |               |             |           |           |           |

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

MAR 12 2004  
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Comments

Comments

Comments

Patent 5636874





### Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination scores is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

**To Test for Authenticity:** Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

### INTERPRETATION OF SCORES

USMLE transcripts include a complete score history and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 140 and 280. An equivalent value score on a two-digit scale is also provided. A score of 75 on the two-digit scale is the recommended minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

### 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 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.

**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 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 of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

UNIVERSITY OF WASHINGTON ACADEMIC TRANSCRIPT  
OFFICE OF THE REGISTRAR

**RECEIVED**

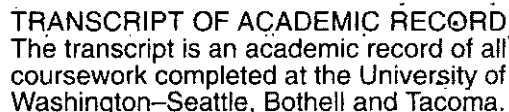
FEB 26 2004

[illegible][illegible][illegible]

|        |     |                          |        |        |        |        |      |                      |        |     |                          |
|--------|-----|--------------------------|--------|--------|--------|--------|------|----------------------|--------|-----|--------------------------|
| HUB101 | 511 | TER-P-GROSS-ANAT&EMBRYO  | 7.0    | S      | 18     | HUB101 | 599  | P-INDP-STUDY-MED-SCI | W.6.0  | GTO | UNIVERSITY OF WASHINGTON |
| HUB101 | 512 | PC-MECH/CELL PHYSIOLOGY  | 5.0    | S      |        | HUB101 | 600  | P-BASIC-ANES-CLKSH   | W.4.0  | GTO | UNIVERSITY OF WASHINGTON |
| HUB101 | 513 | R-P-INTRO-CLIN-MEDISCRIP | 1.0    | N      |        | HUB101 | 601  | P-CHRDIS&DISABILITY  | W.4.0  | GTO | UNIVERSITY OF WASHINGTON |
| HUB101 | 514 | INCPC2-BIOCHEM           | 4.0    | H      |        | HUB101 | 602  | P-CLIN-CLERKSHIP     | W.12.0 | GTO | UNIVERSITY OF WASHINGTON |
| HUB101 | 516 | SRP-SYS-FU-BEHAV/ANEST   | 3.0    | S      |        | HUB101 | 603  | QTR-FA/T-ATTEMPTED   | W.20.0 | GPA | UNIVERSITY OF WASHINGTON |
| HUB101 | 523 | INCPC-INTRO-IMMUNOLOGY   | 2.0    | S      |        | HUB101 | 604  | QTR-FA/T-ATTEMPTED   | W.20.0 | GPA | UNIVERSITY OF WASHINGTON |
| HUB101 | 526 | SRP-SYS-FU-BEH/ANEST     | 3.0    | S      |        | HUB101 | 605  | QTR-FA/T-ATTEMPTED   | W.20.0 | GPA | UNIVERSITY OF WASHINGTON |
| HUB101 | 530 | INCPC-EPIDEMIOLOGY       | 2.0    | S      |        | HUB101 | 606  | QTR-FA/T-ATTEMPTED   | W.20.0 | GPA | UNIVERSITY OF WASHINGTON |
| HUB101 | 531 | QTR-FA/T-ATTEMPTED       | W.29.0 | EARNED | W.29.0 | GPA    | 0.00 |                      |        |     |                          |

[illegible][illegible][illegible][illegible]

**EXPLANATORY NOTES ARE PRINTED ON REVERSE SIDE**





UNIVERSITY OF WASHINGTON  
OFFICE OF THE REGISTRAR

[illegible]

**EXPLANATORY NOTES ARE PRINTED ON REVERSE SIDE**



UoW 1592 (Rev. 10/03)

## EXPLANATORY NOTES

### AUTHENTICATION OF THIS TRANSCRIPT:

A transcript is official when it bears the facsimile signature of the Registrar, the University of Washington Seal, and the production date. The background of this transcript is purple and the Registrar's signature is purple. Further authentication may be obtained by calling the UW Registration/Transcript Office at (206) 543-8580. If photocopied, the word COPY will appear in the background. Alterations to the transcript will result in brown stains and/or white areas.

### ACADEMIC CALENDAR:

The academic year is comprised of three quarters – autumn, winter, spring – each lasting approximately eleven weeks. There is also a summer quarter.

### EXPLANATION OF GRADE SYMBOLS:

Numeric grades: 4.0, 3.9, decreasing by 1/10 to 0.7, 0.0. The highest grade is 4.0. Lowest passing grade is 0.7 (undergraduates), 1.7 (graduate students).

Letter grades: I (incomplete); N (satisfactory without grade); S (passing grade for courses taken on a satisfactory/not-satisfactory basis), for undergraduate students 2.0 and above but prior to autumn 1985 1.7 and above; for graduate students 2.7 and above. NS (not satisfactory grade for courses taken on a satisfactory/not satisfactory basis), for undergraduate students a grade less than 2.0 but prior to autumn 1985 a grade less than 1.7; for graduate students a grade less than 2.7. CR (credit awarded in a course offered on a credit/no credit basis only). The minimum performance level required for a CR grade is determined, and the grade is awarded directly, by the instructor. NC (credit not awarded in a course offered on a credit/no credit basis only); W (official complete withdrawal from the University, or course drop); beginning autumn 1990 for undergraduates and autumn 1997 for graduate and professional students, W accompanied by a number of 3 through 7 (designates course dropped week 3 through week 7 of all quarters except summer quarter); \*W (prior to autumn 1990, a peremptory drop made during the fifth through tenth week of the quarter); HW (Hardship Withdrawal); X (no grade submitted by instructor). Course titles preceded by the letter H designate honors courses, W designate writing courses, and S designate service learning courses. A course title preceded by the letter R designates a course with a research component.

**UNDERGRADUATE NUMERIC GRADE POINT EQUIVALENTS:** 4.0-3.9 (A); 3.8-3.5 (A-); 3.4-3.2 (B+); 3.1-2.9 (B); 2.8-2.5 (B-); 2.4-2.2 (C+); 2.1-1.9 (C); 1.8-1.5 (C-); 1.4-1.2 (D+); 1.1-0.9 (D); 0.8-0.7 (D-); 0.0 (E).

**GRADUATE NUMERIC GRADE POINT EQUIVALENTS:** 4.0-3.9 (A); 3.8-3.5 (A-); 3.4-3.1 (B+); 3.0-2.9 (B); 2.8-2.5 (B-); 2.4-2.1 (C+); 2.0-1.7 (C); 1.6-0.0 (E).

### SPECIAL SYMBOLS:

A grade followed by an I indicates an incomplete was initially awarded but a final grade has been received. Prior to winter 1983, /R indicates course was repeated and only the last grade will count in grade point average and credit is allowed once. Effective winter 1983 through summer 1985, /DR for a repeated course indicates that the first grade was less than a 2.0. Both grades will count in the grade point average but credit will be allowed only once. /R indicates that the first grade was greater or equal to a 2.0 and the second grade does not count in the grade point average and credit is not allowed. Effective autumn 1985, /DR for a repeated course indicates both grades will count in the grade point

average but credit will be allowed only once and X/R is used for an undergraduate indicating the student repeated a course not eligible to be repeated for grade or credit.

Beginning autumn 1987, /R for undergraduates designates a language course initially taken in high school (used for language of admission to the University) and repeated but not allowed credit and not included in the grade point average.

Courses designated with /D indicate the grade counts in the grade point average but credit is not allowed toward degree requirements.

### EXPLANATION OF GRADE SYMBOLS USED PRIOR TO SUMMER QUARTER 1976:

A (honor); B (good); C (medium); D (poor-low pass); E (fail or unofficial withdrawal); EW (failing work at time of official withdrawal after the first fifteen calendar days of the quarter); PW (passing work at time of withdrawal after the first fifteen calendar days of the quarter); S (passing grade for courses 500 and above and for undergraduate courses taken on a credit/no credit basis where credit is awarded).

### SCHOOL OF DENTISTRY:

Effective autumn 1992: Numeric grades: 4.0, 3.9, decreasing by 1/10 to 0.7. The highest grade is 4.0. Lowest passing grade is 0.7. Dental students taking medical school courses are allowed medical school grades.

Prior to autumn 1992: Numeric grades: 4.0 (honor), 3.7, 3.3, 3.0, 2.7, (good), 2.3, 2.0 (low pass), 0.0 (failure). Prior to spring 1981, letter grades: A (4.0), B (3.0), C (2.0), E (failure), EW (failure withdrawal), CR, NC, I, N, W.

### SCHOOL OF LAW:

Effective autumn 1998, for entering first year Law students: Letter grades: A (4.0), A- (3.7), B+ (3.3), B (3.0), C (2.0), D+ (1.0), E (0.0), CR (Credit); NC (No Credit); I (Incomplete); N (satisfactory without grade); W (Withdrawal); HW (Hardship Withdrawal). For Law students entering prior to autumn 1998: DS (Distinguished); H (Honors); P (Pass); LP (Low Pass); CR, NC, I, N, W, HW. Prior to 1990, numeric grades-credit awarded for grades 4.0 through 2.3; letter grades-CR, NC, I, N, \*W, and W.

### SCHOOL OF MEDICINE:

Letter grades: H (Honors), S, NS, CR, NC, I, N, W. Effective autumn 1996: HP (High Pass), P (Pass), F (Fail) were added. Effective autumn 2002, S, NS were discontinued.

### SCHOOL OF PHARMACY:

Numeric grades: 4.0, 3.9, decreasing by 1/10 to 0.7, 0.0. The highest grade is 4.0. Lowest passing grade is 0.7.

### COURSE LEVEL:

Lower division, 100-299; upper division, 300-499; graduate 500 and above.

### TRANSCRIPTS:

Most student records were converted to a new transcript system in winter 1983. You may receive two types of transcripts.

### ACCREDITATION:

The University of Washington is accredited by the Northwest Association of Schools and Colleges.

This educational record is subject to the Family Educational Rights and Privacy Act of 1974, as amended. It is furnished for official use only and may not be released to or accessed by outside agencies, or third parties without the written consent of the student concerned.

**TO TEST FOR AUTHENTICITY:** The face of this document has a purple background and the name of the institution appears in small print.

UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON TRANSCRIPT • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON TRANSCRIPT • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON TRANSCRIPT • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON TRANSCRIPT • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON TRANSCRIPT • UNIVERSITY OF WASHINGTON • UNIVERSITY OF WASHINGTON

**ADDITIONAL TEST:** When photocopied, the word COPY appears prominently across the face of the entire document. A black and white document is not an original and should not be accepted as an official document. This transcript cannot be released to a third party without the written consent of the student. This is in accordance with the Family Educational Rights and Privacy Act of 1974. If you have additional questions about this document, please contact our office at (206) 543-8580.

TO: Post Graduate Training Program Director

VENTURA COUNTY FAMILY PRACTICE RESIDENCY

FACILITY NAME

3291 Loma Vista Rd

ADDRESS

VENTURA, CA 93003

RECEIVED  
MAR 12 2004  
DEPARTMENT OF HEALTH  
HEALTH PROFESSIONS 5

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 show below. **All questions must be answered.**

TAYLOR MICHAEL DUNN

APPLICANT (PRINT OR TYPE)

3/9/68

BIRTHDATE

*Taylor Dunn MD*

SIGNATURE OF APPLICANT

1. Taylor Dunn is or was engaged in post-graduate training in our program

from 7/99 to 6/02

BEGINNING DATE (MONTH & YEAR)

ENDING DATE (MONTH & YEAR)

in the field of Family Medicine

2. At the time this individual completed training, was this program accredited through the Accreditation Council for Graduate Medical Education? ☒ Yes ☐ No

3. Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evaluations conducted.)

Dr Dunn performed very well

as a family medicine resident.

His performance evaluations were

all satisfactory

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

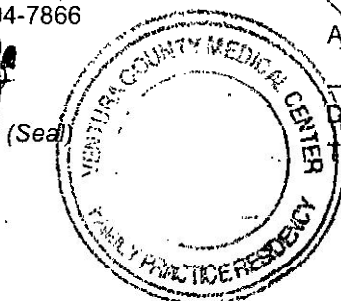
5. Is there anything in the participant's file which would indicate he/she would be unable to safely practice medicine? ☐ Yes ☒ No If yes, please provide documentation.

6. We would appreciate any further documentation you feel would assist in the evaluation process. Thank you.

Return to:

Medical Quality Assurance Commission  
1300 SE Quince Street  
P O Box 47866  
Olympia, WA 98504-7866  
(360) 236-4785 (A-L)  
(360) 236-4784 (M-Z)

Signature Taylor Dunn  
Title Residency Program Director  
Hospital Ventura County Medical Center  
Address 3291 Loma Vista Rd  
Ventura CA 93003  
Date 3-5-04  
Telephone 805 652 6228





**Department of Community  
and Economic Development**

**Division of Occupational Licensing**

P.O. Box 110806, Juneau, AK 99811-0806

Telephone: (907) 465-2534 • Fax: (907) 465-2974 • Text Telephone: (907) 465-5437

Email: License@dced.state.ak.us • Website: www.dced.state.ak.us/occ/

**RECEIVED**

**MAR 08 2004**

**CERTIFICATION**

I, **Sher Zinn**, Licensing Examiner, Division of Occupational Licensing, Department of Community and Economic Development, State of Alaska, certify that I am the keeper of the records of the **STATE MEDICAL BOARD** and that these records indicate that the following individual is/was licensed as shown:

Name: **TAYLOR MICHAEL DUNN**

License Type: **IS A LICENSED PHYSICIAN**

License Number: **4865**

Date Originally Issued: **08/05/2002**

Expiration Date: **12/31/2004**

Date of Birth: **03/09/1968**

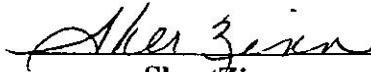
Comments:

**No licensing action on file.**

Dated this **Third day of March, 2004**

SEAL



  
\_\_\_\_\_  
**Sher Zinn**  
Licensing Examiner

*"Promoting a healthy economy and strong communities"*



## MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM  
1426 HOWE AVE, SUITE 54  
SACRAMENTO CA 95825-3236  
TELEPHONE: (916) 263-2382  
FAX: (916) 263-2944

[www.medbd.ca.gov](http://www.medbd.ca.gov)



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MAR 25 2004

DEPARTMENT OF HEALTH  
HEALTH PROFESSIONS 5

March 16, 2004

WASHINGTON DEPT OF HEALTH  
MEDICAL QUALITY ASSURANCE COMMISSION  
PO BOX 47866  
OLYMPIA WA 98504-7866

To Whom It May Concern:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

|                  |                       |
|------------------|-----------------------|
| Physician:       | TAYLOR MICHAEL DUNN   |
| License No.:     | A 73208               |
| Issued:          | October 5, 2000       |
| Exam Type:       | A written examination |
| Expiration Date: | March 31, 2006        |
| Status:          | Renewed/current       |

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File Room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

Lucinda James  
Chief, Division of Licensing

SEAL





MD

RECEIVED

MAR 01 2004

DEPARTMENT OF HEALTH  
HEALTH PROFESSIONS 5

TO: Hospital Administration

VENTURA COUNTY MEDICAL CENTER

HOSPITAL NAME

3291 Loma Vista Road

ADDRESS

VENTURA, CA 93003

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 therefore authorizing the release of and would appreciate you providing the appropriate information **directly** to the address show below at your earliest convenience. **All questions must be answered.**

TAYLOR MICHAEL DUNN

APPLICANT (PRINT OR TYPE)

3/9/68

BIRTHDATE

Taylor Dunn MD

SIGNATURE OF APPLICANT

1. Taylor Dunn MD ~~now has~~/has had ~~admitting or~~ specialty privileges at this hospital  
from 10/11/00 to 11/27/02  
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

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. Is there any information in your files which would indicate the applicant's inability to safely practice medicine?

☐ Yes ☒ No If yes, please explain

5. We would appreciate any information you feel would assist in the evaluation process. Thank you.

## Return to:

Medical Quality Assurance Commission  
1300 SE Quince Street  
P O Box 47866  
Olympia, WA 98504-7866  
(360) 236-4785 (A-L)  
(360) 236-4784 (M-Z)

(Seal)

no seal

Signature

Title

Hospital

Address

Date

Telephone

David Hutchins CPE

Medical Staff Credentials

Ventura County Medical Ctr.

3291 Loma Vista Road  
Ventura, Ca 93003

2/24/04

(805) 652-6062



MD

TO: Hospital Administration

RECEIVED

FEB 23 2004

MANILAO HEALTH CENTER

HOSPITAL NAME

KOTZEBUE, AK 99752

ADDRESS

DEPARTMENT OF HEALTH  
HEALTH PROFESSIONS 6

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 therefore authorizing the release of and would appreciate you providing the appropriate information directly to the address show below at your earliest convenience. All questions must be

TAYLOR MICHAEL DUNN

APPLICANT (PRINT OR TYPE)

3/9/68

BIRTHDATE

Taylor Dunn MD

SIGNATURE OF APPLICANT

1. Taylor Dunn now has/had admitting or specialty privileges at this hospital  
from 5/02 to Present  
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

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. Is there any information in your files which would indicate the applicant's inability to safely practice medicine?

☐ Yes ☒ No If yes, please explain

5. We would appreciate any information you feel would assist in the evaluation process. Thank you.

## Return to:

Medical Quality Assurance Commission  
1300 SE Quince Street  
P O Box 47866  
Olympia, WA 98504-7866  
(360) 236-4785 (A-L)  
(360) 236-4784 (M-Z)

(Seal)

Signature

Title

Hospital

Address

Date

Telephone

Michael Dunn

Medical Director

Manilao Health Center

PO Box 43

Kotzebue, AK 99752

2/17/04

907-442-7483



MD

TO THE APPLICANT

Complete the identifying information below and submit to:

Federation of State Medical Boards  
Federation Place  
400 Fuller Wiser Road, Suite 300  
Euless, TX 76039-3855

RECEIVED

FEB 26 2004

DEPARTMENT OF HEALTH  
HEALTH PROFESSIONS 5

Department of Health  
Medical Quality Assurance Commission  
1300 SE Quince Street  
P.O. Box 47866  
Olympia, WA 98504-7866

Date: 2/15/04

I am applying for licensure to practice medicine in the state of Washington. Please indicate on the lower portion of this letter if there is any previous or pending disciplinary action against my license(s) and send this information directly to the Washington State Medical Quality Assurance Commission. Thank you for your assistance.

NAME: TAYLOR MICHAEL DUNN

SSN: 1 - DOH Licensee Social Security Numbe...

MEDICAL SCHOOL: UNIVERSITY OF WASHINGTON

YEAR OF GRADUATION: '99

BIRTHDATE: 3/9/68

SIGNATURE: Taylor Dunn MD

WE HAVE NO UNFAVORABLE INFORMATION  
REGARDING THE ABOVE NAMED PHYSICIAN

RESPONSE:

FEB 24 2004

Dale L. Austin  
DALE L. AUSTIN  
SENIOR VICE PRESIDENT  
AND CHIEF OPERATING OFFICER

# American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources  
515 North State Street  
Chicago, Illinois 60610  
<http://www.ama-assn.org/amaprofiles>



## AMA Physician Profile

**RECEIVED**

**MAR 05 2004**

DEPARTMENT OF HEALTH  
HEALTH PROFESSIONS 5

**Name and Mailing Address:**

TAYLOR MICHAEL DUNN MD  
436 & 5TH TED STEVENS WAY  
PO BOX 1281  
KOTZEBUE AK 99752-1281

**Primary Office Address:**

SAME AS MAILING ADDRESS

**Phone:** UNKNOWN

**Birthdate:** 03/09/1968

**Birthplace:** MISSOULA, MT UNITED STATES OF AMERICA

**Physician's Major Professional Activity:** OFFICE BASED PRACTICE

**Practice Specialties Self Designated by the Physician:**

**Primary Specialty:** FAMILY MEDICINE

**Secondary Specialty:** UNSPECIFIED

**AMA membership:** NON MEMBER

\_\_\_\_\_ **Data From This Point Forward is Primary Source Reported** \_\_\_\_\_

**Current and/or Historical Medical School:**

UNIV OF WA SCH OF MED, SEATTLE WA 98195

**Reported Year of Graduation:** 1999

**Degree Awarded:** Yes

## AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however*, that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties, either expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.

# American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources  
515 North State Street  
Chicago, Illinois 60610  
<http://www.ama-assn.org/amaprofiles>



## 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: VENTURA CO MED CTR  
Specialty : FAMILY PRACTICE

State: CALIFORNIA  
07/1999 - 06/2002  
(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:

| <u>Jurisdiction</u> | <u>MD/DO</u> | <u>Date Granted</u> | <u>Expiration Date</u> | <u>Status</u> | <u>License Type</u> | <u>Last Reported</u> |
|---------------------|--------------|---------------------|------------------------|---------------|---------------------|----------------------|
| ALASKA              | MD           | 08/05/2002          | 12/31/2004             | ACTIVE        | UNLIMITED           | 02/16/2004           |
| CALIFORNIA          | MD           | 10/05/2000          | 03/31/2004             | ACTIVE        | UNLIMITED           | 08/25/2003           |

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.

### ECFMG Certification:

#### 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.

### Federal Drug Enforcement Administration:

FEDERAL DEA REGISTRATION INFORMATION WAS LAST REPORTED TO THE AMA ON 01/06/2004.  
DEA REGISTRATION IS VALID THROUGH 06/30/2006.

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.

## AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however*, that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties, either expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.

# American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources  
515 North State Street  
Chicago, Illinois 60610  
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## AMA Physician Profile

### 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:

**Certifying Board:** AMERICAN BOARD OF FAMILY PRACTICE

**Certificate:** FAMILY PRACTICE

**Certificate Type:** GENERAL

| <u>Duration</u> | <u>Effective</u> | <u>Expiration</u> | <u>Occurrence</u> | <u>Last Reported</u> |
|-----------------|------------------|-------------------|-------------------|----------------------|
| TIME LIMITED    | 07/12/2002       | 12/31/2009        | INITIAL           | 01/14/2004           |

**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.

### 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 ADMINISTRATION OR THE US PUBLIC HEALTH SERVICE.

### 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 on Accreditation of Healthcare Organizations (JCAHO) 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 mark them on a copy of the profile and mail or fax to:

Division of Survey and Data Resources  
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515 N. State Street  
Chicago, IL 60610  
312 464-5199  
312 464-5900 (fax)



## AMA Physician Profile (continued)

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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

March 05, 2004

Attn: Doron Maniece  
Washington Quality Med Assur  
P.O. Box 47866  
310 Israel Road SE  
Tumwater, WA 98501

Re: Board Action Query Dated: March 05, 2004  
Your Reference Number:  
FSMB Batch Number: BQ922000

The following is a report of the search results from the Board Action Data Bank as of March 05, 2004 for practitioners submit above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of March 05, 2004

---

| Item | Name                    | DOB        | School | Yr/Grad |
|------|-------------------------|------------|--------|---------|
| 2    | Cooper, Emily           | 09/04/1974 | 028020 | 2001    |
| 1    | Cuschieri, Joseph       | 10/01/1968 | 023040 | 1994    |
| 3    | Dong, Zhao              | 01/02/1963 | 243475 | 1983    |
| 5    | Dunn, Taylor            | 03/09/1968 | 048010 | 1999    |
| 6    | Handy, Robert           | 07/08/1963 | 039080 | 1989    |
| 7    | Hankins-Cessna, Melissa | 12/18/1971 | 032010 | 1999    |
| 9    | Hsu, Yung               | 03/28/1972 | 044070 | 1999    |
| 10   | Liskow, Arthur          | 03/05/1941 | 036020 | 1967    |
| 8    | Liu, Clive              | 09/22/1971 | 033080 | 1998    |

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515 North State Street  
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## AMA Physician Profile

### *Name and Mailing Address:*

TAYLOR MICHAEL DUNN MD  
436 & 5TH TED STEVENS WAY  
PO BOX 1281  
KOTZEBUE AK 99752-1281

### *Primary Office Address:*

SAME AS MAILING ADDRESS

**Phone:** UNKNOWN

**Birthdate:** 03/09/1968

**Birthplace:** MISSOULA, MT UNITED STATES OF AMERICA

**Physician's Major Professional Activity:** OFFICE BASED PRACTICE

### **Practice Specialties Self Designated by the Physician:**

**Primary Specialty:** FAMILY MEDICINE

**Secondary Specialty:** UNSPECIFIED

**AMA membership:** NON MEMBER

\_\_\_\_\_ **Data From This Point Forward is Primary Source Reported** \_\_\_\_\_

### **Current and/or Historical Medical School:**

UNIV OF WA SCH OF MED, SEATTLE WA 98195

**Reported Year of Graduation:** 1999

**Degree Awarded:** Yes

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Chicago, IL 60610  
312 464-5199  
312 464-5900 (fax)



STATE OF WASHINGTON  
DEPARTMENT OF HEALTH  
Olympia, Washington 98504

March 10, 2004

Taylor Dunn MD  
POB 1281  
Kotzebue AK 99752

Dear Dr Dunn

---

This is to acknowledge receipt of your application for licensure as a physician and surgeon in the state of Washington.

**Your application and fee of \$325.00 was received on March 3, 2004**

**MISSING ITEMS**

**Disposition of malpractice**

**USMLE**

**Post Graduate Training Verification**

**License Verification CA**

A deficiency letter will be sent about every four weeks until the application is considered complete. Please understand deficiency letters are our way of notifying you what is lacking in your file. An over abundance of phone calls simply slows the process down as it diverts staff resources from application processing. We appreciate your consideration of staff resources and your patience with the process.

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 [betty.elliott@doh.wa.gov](mailto:betty.elliott@doh.wa.gov), or write to me at Department of Health, Medical Quality Assurance Commission, P O Box 47866, Olympia, WA 98504-7866.

Sincerely,

Betty Elliott, Licensing Representative



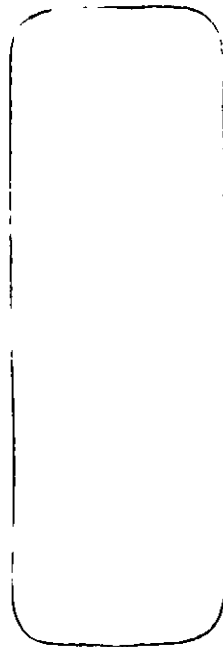
UNIVERSITY OF WASHINGTON

OFFICE OF THE REGISTRAR

Box 35850

Seattle, Washington 98195-5850

03-3900



Taylor Dunn  
P.O. Box 1281  
KOTZESQUE, AK  
99752



POSTAGE

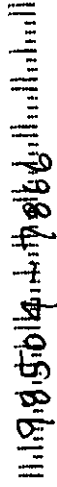
MAY 07 2004

99752

DEPT OF HEALTH  
MEDICAL QUALITY ASSURANCE Commission

1300 S.E. QUINCE ST  
P.O. Box 47866  
OLYMPIA, WA

92504#7866





Redaction Summary ( 5 redactions )

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1 Privilege / Exemption reason used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" ( 5 instances )

Redacted pages:

- Page 1, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 7, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 18, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 20, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 27, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance