STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Sean Parnell, Governor
Emil Notti, Commissioner
Lynne Smith, Director

Division of Corporations, Business and Professional Licensing

ALASKA STATE MEDICAL BOARD

MED S 4340

JOEY MICHELE BANKS
16601 VIRGO AVE
ANCHORAGE AK 99516

13 August 2009

Our records indicate that your Alaska license to practice medicine lapsed on December 31, 2008.

If it is your intention to allow your Alaska license to lapse due to nonpayment of renewal fees, please disregard this letter.

If you have not renewed your license and wish to practice medicine in Alaska, please be aware that your license is currently lapsed. If you are practicing medicine in the state of Alaska at this time, you are in violation of the law.

If you wish to reinstate your lapsed license, please review the following regulation:

> **12 AAC 40.025. LAPSED PHYSICIAN LICENSES.** (a) A physician license that has been lapsed for at least 60 days but less than one year will be reinstated if the applicant
> (1) submits a completed renewal application on a form provided by the department;
> (2) pays the applicable biennial license renewal fee established in 12 AAC 02.250(a);
> (3) submits proof of meeting the continuing medical education requirements in 12 AAC 40.200 - 12 AAC 40.220; and
> (4) receives clearance from the Federation of State Medical Boards and documentation of the clearance is sent directly to the division by that federation.
> (b) A physician license that has been lapsed for at least one year but less than five years will be reinstated if the applicant meets the requirements in (a)(2), (3), and (4) of this section and
> (1) submits a completed reinstatement application on a form provided by the department;
> (2) receives clearance from the federal Drug Enforcement Administration (DEA) and documentation of the clearance is sent directly to the division by the DEA;
> (3) arranges for verification of licensure to be sent directly to the division from each state other than Alaska where the applicant is or has been licensed as a physician;
> (4) is qualified for a license under AS 08.64.230 and is not disqualified by AS 08.64.240; and
> (5) arranges for a verification of hospital privileges to be sent directly to the division, from each hospital where the applicant has held privileges within the five years immediately before the date that the applicant signs the application form.
> (c) Notwithstanding (a) and (b) of this section, the board may refuse to reinstate a physician license for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

Please feel free to contact our office if you have any questions or require additional information.

Leslie A. Gallant
Executive Administrator
Alaska State Medical Board

550 West Seventh Avenue, Suite 1500, Anchorage, AK 99501-3567
Telephone (907) 269-8163 Fax: (907) 269-8196 Website: www.commerce.state.ak.us/occ/pmed.htm

CERTIFICATION

I, **Colleen Wilson**, Licensing Examiner, Division Corporations, Business and Professional Licen Department of Commerce, Community and Economic Development, State of Alaska, certify that the keeper of the records of the **STATE MEDICAL BOARD** and that these records indicate tha the following individual is/was licensed as shown:

Name: **JOEY MICHELE BANKS**
License Type: **IS A LICENSED PHYSICIAN**
License Number: **4340**
Date Originally Issued: **11/15/1999**
Expiration Date: **12/31/2008**
Date of Birth: [redacted]

Comments:

No licensing action in State of Alaska
Other License held:

#648	**Resident**	**Issued 07/08/99**	**Exp 07/7/99**	**No Action**
#1059	**Resident**	**Issued 06/30/99**	**Exp 12/30/00**	**No Action**
#1230	**Temp**	**Issued 09/28/99**	**Exp 03/28/00**	**No Action**

Dated this **Fourth day of May, 2007**

SEAL

Colleen Wilson
Licensing Examiner

854318

MED

✓ 20 [illegible]

State of Alaska
Department of Commerce, Community, and Economic Development
Division of Occupational Licensing
P.O. Box 110806
Juneau, Alaska 99811-0806
Telephone: (907) 465-2534
Fax: (907) 465-2974
E-mail: license@commerce.state.ak.us
Website: www.commerce.state.ak.us/occ

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MAY 0 3 2007
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

REQUEST FOR LICENSE VERIFICATION

To request an official signed and sealed document verifying your Alaska license, certification, or registration to be sent to another state or agency, please complete this form and submit it along with the **$20.00 verification fee** to the address listed above. Make checks payable to "State of Alaska." If you would like the verification returned by express courier, please submit a prepaid addressed envelope. Requests are generally processed within 10 to 14 days of receipt.

PROFESSION: MD

License Number: AK 4340   License Type: MD

Is license current? ☒ Yes ☐ No   License Expiration Date: 12/31/08

Name: Banks (Last)   Joey (First)   michele. (Middle)

Mailing Address: 16601 Virgo Ave (Street)

Anchorage (City)   AK (State)   99516 (Zip Code)

Is this a change of address? ☐ Yes ☒ No

Provide Name and Address of agency receiving license verification: ($20.00 per mailing)

(1) Maine Board of Licensure in Medicine
137 State House Station
161 Capitol St
Augusta ME 04333-0137.

(2)

Signature: [signature]   Date: 4/19/07

08-4222 (New 12/06/04)tf

please send check receipt to my address

0005

RECEIVED
MAY 0 3 2007
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

VERIFICATION OF LICENSE – STATE/PROVINCE/COUNTRY

SECRETARY:
I am applying for medical licensure in the State of Maine, USA. The Maine Board of Licensure in Medicine requires that your Board complete this form in order that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the Maine Board of Licensure in Medicine.

Joey Michele Banks
Print/Type Full Name

[signature]
Signature

4/7/07
Date

AK 4340
License Number

11/15/99
Date Issued

16601 Virgo Ave
Address

Anchorage AK 99516
City State Zip Code

THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE BOARD

Name of Licensing Authority: ____________________

Mailing Address of Licensing Authority: ____________________

Name of Licensee: ____________________ Date of Birth: ___/___/___ (Month Day Year)

License Number: ____________________ Date Issued: ___/___/___ (Month Day Year) Expiration Date: ___/___/___ (Month Day Year)

The license to practice medicine was issued on the basis of the following examination(s):

☐ FLEX ☐ NBME ☐ USMLE ☐ LMCC ☐ STATE ☐ OTHER: ______

☐ GENERAL MEDICAL COUNCIL OF THE UNITED KINGDOM ☐ REPUBLIC OF IRELAND

Medical School: ____________________ Graduation Date: ___/___/___ (Month Day Year)

Is this license current? ☐Yes ☐No If No, please explain: ____________________

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state that is likely to result in formal disciplinary proceedings within one year of this date and/or reflects a pattern of misconduct and/or that conduct could be considered criminal in nature? ☐Yes ☐No ☐Cannot answer under state law

Have formal disciplinary proceedings been initiated against the applicant's license by a disciplinary authority in your state?

☐Yes ☐No ☐Cannot answer under state law

Has the applicant ever been warned, censured or in any other manner disciplined or has the applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state

☐Yes ☐No ☐Cannot answer under state law

If you have responded "YES" to any of the above, please provide an explanation below:

____

Please affix Board Seal here

____________________ ___/___/___
Signature of Board Official Date

____
Title

Thank you for your cooperation.

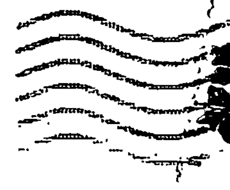
Please return this form to:

Maine Board of Licensure in Medicine
137 State House Station
161 Capitol Street
Augusta, ME 04333-0137
USA

Banks
1601 Virgo Ave
Anchorage AK 99516

ANCHORAGE AK 995

01 MAY 2007 PM 1 T



State of Alaska
Department of Commerce, Community & Ec
Division of Occupational Licensing
PO Box 110806
Juneau AK 99811-0806

0007

99811+0806

No. 4340
Effective: 10/31/2006
Expires: 12/31/2008

STATE OF ALASKA

DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT

Division of Occupational Licensing

STATE MEDICAL BOARD

Certifies that

JOEY MICHELE BANKS

IS A LICENSED

PHYSICIAN

Commissioner: William C. Noll

Wallet Card

No. 4340 State Of Alaska

Department of Commerce, Community, and Economic Development
Division of Occupational Licensing

JOEY MICHELE BANKS

IS A LICENSED
PHYSICIAN

Effective	Expiration	Date of Birth
10/31/2006	12/31/2008	[redacted]

Signature ____________________

IT IS YOUR RESPONSIBLITY TO BE AWARE OF THE CONTINUING EDUCATION REQUIREMENTS FOR RENEWAL.

WALL CERTIFICATES SUITABLE FOR FRAMING ARE AVAILABLE FOR A FEE OF $20.

THE FEE FOR VERIFICATIONS OF LICENSURE OR LETTERS OF GOOD STANDING IS $20.

PER 12 AAC 02.900 YOU MUST NOTIFY US IN WRITING IF YOU CHANGE YOUR MAILING ADDRESS. YOU MAY FAX YOUR ADDRESS CHANGE TO (907) 465-2974.

Division Website: www.commerce.state.ak.us/occ

MED

JOEY MICHELE BANKS
16601 VIRGO AVE
ANCHORAGE AK 99516

STATE MEDICAL BOARD

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
P.O. Box 110806, Juneau, Alaska 99811-0806

Physician - Biennial License Renewal
October 20 2006 - December 31 2008

Online Renewal

Personal Information:

Name BANKS JOEY MICHELE

License MEDS4340

Address of Record
16601 VIRGO AVE

ANCHORAGE AK 99516

Alternate Address
16601 VIRGO AVE

ANCHORAGE AK 99516

Spec FAMILY PRACTICE

States

Phone 907-274-5175 **Fax** 907-565-7529

Email alaskabanks@acsalaska.net

Web Information:

Reciept 660197 **Web Date** 10/31/06 **XID** 19064053

Auth Code 02581B **Web Total** 590 **Successfull** Y

Only the license holder is authorized to renew their license on-line. Use of the on-line program by anyone other than the licensee is prohibited. WARNING: It is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

I affirm that I am the individual applying for the renewal of this license. I further certify that the information provided is true and correct. I understand that all information is subject to review. YES

Professional Fitness Questions

1 Has your professional license been denied, revoked, suspended, surrendered, fined, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction (including Alaska), including military authorities, or is any such action pending? NO

2 Have you voluntarily or involuntarily surrendered or restricted your professional license in any jurisdiction for any reason or is any such action pending? NO

3 Have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (for other than late medical records) or is any such action pending? NO

4 Have you been convicted of a felony or misdemeanor, other other than minor traffic violations, under the laws of any local, state, or federal jurisdiction of the United States or any other country or is any such action pending? NO

5 Have you been the subject of an investigation by any licensing jurisdiction or are you currently under investigation by any licensing jurisdiction or is any such action pending? NO

6 Have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under inquiry or investigation? NO

7 Have you been notified of any complaint or allegations involving you filed with or by any licensing authority, including Alaska, which complaint or allegations remain open as of the date of this application? NO

8 Have you experienced, been diagnosed with, been evaluated for, or treated for any alcohol or other chemical abuse, dependency, or impairment? NO

9 Have you experienced, been diagnosed with, been evaluated for, or treated for any physical or mental condition which may impair or interfere with your ability to safely practice medicine? NO

10 Have you experienced, been diagnosed with, been evaluated for, or treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder? NO

11 Has a medical malpractice claim been resolved or a civil action been terminated in which damages have been paid or are to be paid by you or on your behalf to a claimant or plaintiff, whether by judgment or under settlement? NO

12 Have you been investigated or disciplined by the Drug Enforcement Administration or have you surrendered your federal or any state controlled substance registration for any reason or is any such action pending? NO

Continuing Education Questions

CE1 I hereby affirm that I have been awarded the required CME and have complied with the continuing medical education requirements set forth in regulations 12 AAC 40.200-240 for the license period 01/01/2005 through 12/31/2006.

No. 4340
Effective: 10/24/2004
Expires: 12/31/2006

STATE OF ALASKA

DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT

Division of Occupational Licensing

STATE MEDICAL BOARD

Certifies that

JOEY MICHELE BANKS

IS A LICENSED

PHYSICIAN

Commissioner: Edgar Blatchford

Wallet Card

No. 4340 State Of Alaska

Department of Commerce, Community, and Economic Development

Division of Occupational Licensing

JOEY MICHELE BANKS

IS A LICENSED

PHYSICIAN

Effective	Expiration	Date of Birth
10/24/2004	12/31/2006	[redacted]

Signature ____________________

IT IS YOUR RESPONSIBLITY TO BE AWARE OF THE CONTINUING EDUCATION REQUIREMENTS FOR RENEWAL.

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Division Website: www.dced.state.ak.us/occ

MED

JOEY MICHELE BANKS
16601 VIRGO AVE
ANCHORAGE AK 99516

STATE MEDICAL BOARD

Department of Community and Economic Development
Division of Occupational Licensing
P.O. Box 110806, Juneau, Alaska 99811-0806
Physician - Biennial License Renewal
October 1 2004 - December 31 2006

License 4340

Name BANKS JOEY MICHELE
Address 16601 VIRGO AVE
ANCHORAGE AK 99516

Web Information:

Reciept	524524	**Web Date**	10/24/04	**XID**	1122798€
Auth Code	001884	**Web Total**	590	**Successfull**	Y

Professional Fitness Questions

Has your professional license been denied, revoked, suspended, surrendered, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction, including military authorities?	NO
Has a medical malpractice claim been resolved or a civil action been terminated in which damages hav been paid, or are to be paid, by you, or on your behalf to a claimant or plaintiff, whether by judgment or under settlement?	NO
Have you been investigated by the Drug Enforcement Administration or have you surrendered your federal or any state controlled substance registration for any reason?	NO
Have you voluntarily or involuntarily surrendered or restricted your professional license in any jurisdiction?	NO
Have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (other than for late medical records)?	NO
Have you been convicted of any criminal offense, other than minor traffic violations, under the laws of any local, state, or federal jurisdiction of the United States or any other country?	NO
Have you been the subject of an investigation by any licensing jurisdiction or are you currently under investigation by any licensing jurisdiction?	NO
Have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under inquiry or investigation?	NO
Have you experienced, been diagnosed with, been evaluated for, or treated for any alcohol or other chemical abuse, dependency, or impairment?	NO
Have you experienced, been diagnosed with, been evaluated for, or treated for any physical or mental condition which may impair or interfere with your ability to safely practice medicine?	NO
Have you experienced or been treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder?	NO

Continuing Education Questions

CE1 I hereby affirm that between January 1, 2003 through December 31, 2004, I was awarded the continui medical education hours as set forth in regulations 12 AAC 40.200-240.

No. 4340
Effective: 11/25/2002
Expires: 12/31/2004

STATE OF ALASKA

DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT
Division of Occupational Licensing
P.O. Box 110806, Juneau, Alaska 99811-0806

STATE MEDICAL BOARD

Certifies that

JOEY MICHELE BANKS

IS A LICENSED

PHYSICIAN

Commissioner: Deborah B. Sedwick

Wallet Card

No. 4340 State Of Alaska
Department of Community and Economic Development
Division of Occupational Licensing

JOEY MICHELE BANKS
IS A LICENSED
PHYSICIAN

Effective	Expiration	Date of Birth
11/25/2002	12/31/2004	[redacted]

Signature ______________________________

IT IS YOUR RESPONSIBLITY TO BE AWARE OF THE CONTINUING EDUCATION REQUIREMENTS FOR RENEWAL.

WALL CERTIFICATES SUITABLE FOR FRAMING ARE AVAILABLE FOR A FEE OF $20.

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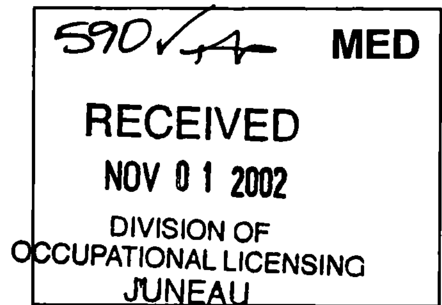
JOEY MICHELE BANKS
16601 VIRGO AVE
ANCHORAGE AK 99516

MED

ALASKA STATE MEDICAL BOARD

Department of Community & Economic Development
Division of Occupational Licensing
P. O. Box 110806
Juneau AK 99811-0806
E-mail: license@dced.state.ak.us

A – K: (907) 465-2756
L – Z: (907) 465-2541



[Joey Banks, MD
4320 Diplomacy Drive
Anchorage AK 99508
#4340]

MEDICAL LICENSE (MD, DO, DPM) RENEWAL APPLICATION 612161

For the period of January 1, 2003 thru December 31, 2004

INSTRUCTIONS - Please read carefully.

Your license to practice medicine in Alaska lapses December 31, 2002. There is no grace period. It is illegal for you to practice if your license is lapsed. To renew your license for the coming license period, please return this signed application to the above address with a check or money order payable to the State of Alaska. **This is the only renewal notice you will receive.** If you wish to receive confirmation that the board has received your renewal, mail it certified, return receipt requested. Receipt of the renewal form does not mean processing is complete or that a renewed license has been issued.

RENEWAL DUE DATE For renewal prior to December 31, 2002, **your completed renewal form and fees must be received in our office no later than December 1, 2002. Processing of a complete renewal takes three to four weeks from the date of receipt in our office – plan accordingly.** Your renewal will be rejected if the form is incomplete or insufficient fees are received.

NAME CHANGE If you have had a legal name change since your last license was issued, enclose a certified true copy of the legal document (marriage certificate, divorce decree, etc.) as proof of the change.

SOCIAL SECURITY NUMBERS In accordance with AS 08.01.100(e), the department is not authorized to renew a license unless the licensee's social security number has been provided to the department.

LAPSED LICENSES If you choose not to renew your license before it lapses, you may renew the license at a later date only after meeting the requirements of regulation 12 AAC 40.025 (see page 4). Licenses that are expired for more than five years may not be renewed.

INACTIVE LICENSES You may not practice medicine or write prescriptions in Alaska with an inactive license. BEFORE YOU RENEW YOUR LICENSE AS INACTIVE, please carefully review 12 AAC 40.033, page 4, regarding reactivation requirements .

RETIRED LICENSES There is a one-time fee for the remainder of the licensee's lifetime. A physician may not practice medicine on a retired license, nor is there a requirement to meet CME under a retired license. BEFORE YOU RETIRE YOUR LICENSE, please carefully review 12 AAC 40.031 regarding reactivation requirements that are included in this renewal (page 4).

PAYMENT OF CHILD SUPPORT OR STUDENT LOANS If the Alaska Child Support Enforcement Division has determined you are in arrears on child support, or if the Alaska Commission on Post-Secondary Education has determined you are in loan default, you will be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Enforcement at (907) 269-6686, (907)269-6688, or 1-800/478-3300 or Post-Secondary Education at 1-888/441-2961 to resolve payment issues.

PUBLIC INFORMATION All information on this renewal form will be available to the public unless required to be kept confidential by law. Current licensee information, including mailing address, is available on the Division of Occupational Licensing's website at www.dced.state.ak.us/occ under "Occupational License Search."

Check appropriate box: ☒ **ACTIVE LICENSE $590** ☐ **INACTIVE LICENSE $250** (Please read 12 AAC 40.025) ☐ **RETIRED LICENSE $100** (Please read 12 AAC 40 031.)

PERSONAL INFORMATION: **(PRINT LEGIBLY OR TYPE)**

NAME (Last, First, Middle)		SEX:
Banks Joey Michele		☐ M ☒ F
PRACTICE ADDRESS (Complete address)		Use as Address of Record:
4320 Diplomacy Drive Anchorage AK 99508		☒
RESIDENCE ADDRESS (Complete address)		Use as Address of Record:
16601 Virgo Ave Anchorage AK 99516		☐
WORK TELEPHONE: 907 729 3317	E-MAIL ADDRESS: jmbanks@anmc.org	
SOCIAL SECURITY NO.: [redacted]	DATE OF BIRTH (MM/DD/YYYY) [redacted]	ALASKA LICENSE NO. AK 4340

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DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

REQUIRED INFORMATION **(Information required to update the board's license database.):**

MEDICAL SCHOOL (Name of school) Indiana University		Year of Graduation 1998
LOCATION (City, State) Indianapolis Indiana		Country USA
PRACTICE SPECIALTY Family Practice	SUBSPECIALTY	SUBSPECIALTY

LIST **ALL** OTHER STATES AND/OR PROVINCES OF CANADA OR OTHER JURISDICTIONS IN WHICH YOU HOLD OR HAVE EVER HELD A LICENSE TO PRACTICE MEDICINE ______________________

PROFESSIONAL CONDUCT: The following questions must be answered. "Yes" answers do not automatically result in license denial. If you answer "Yes" to any question, attach a detailed explanation including dates and circumstances. Attach copies of supporting documents that are applicable (court records, copies of actions, etc.). **Failure to attach a detailed explanation will result in the application being rejected. Please read each question carefully. Please check the appropriate response to the questions below.**

CONFIDENTIALITY: The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

Since the date of your last application for a license to practice medicine in Alaska, or within the past two years:

1. [X] NO [ ] YES Has your professional license been denied, revoked, suspended, surrendered, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction, including military authorities?

2. [X] NO [ ] YES Have you voluntarily or involuntarily surrendered or restricted your professional license in any jurisdiction?

3. [X] NO [ ] YES Have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (OTHER THAN LATE MEDICAL RECORDS)?

4. [X] NO [ ] YES Have you been convicted of a felony or misdemeanor, other than minor traffic violations, under the laws of any local, state, or federal jurisdiction of the United States or any other country?

5. [X] NO [ ] YES Have you been the subject of an investigation by any licensing jurisdiction or are you currently under investigation by any licensing jurisdiction?

6. [X] NO [ ] YES Have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under inquiry or investigation?

7. [X] NO [ ] YES Have you experienced, been diagnosed with, been evaluated for, or treated for any alcohol or other chemical abuse, dependency, or impairment?

8. [X] NO [ ] YES Have you experienced, been diagnosed with, been evaluated for, or treated for any physical or mental condition which may impair or interfere with your ability to safely practice medicine?

9. [X] NO [ ] YES Have you experienced, been diagnosed with, been evaluated for, or treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder?

(Questions Continued on Next Page)

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DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

10. [X] NO [ ] YES Has a medical malpractice claim been resolved or a civil action been terminated in which damages have been paid, or are to be paid, by you, or on your behalf to a claimant or plaintiff, whether by judgment or under settlement?

11. [X] NO [ ] YES Have you been investigated by the Drug Enforcement Administration or have you surrendered your federal or any state controlled substance registration for any reason?

CONTINUING MEDICAL EDUCATION

As provided by regulations 12 AAC 40.200, 210, 220, and 240, your license cannot be renewed unless you have met continuing medical education requirements. Those regulations are provided on page 4 of this application. Individuals who are renewing their licenses in "Retired" status are not required to complete CME.

If your license number is:	From 01/01/2001 to 12/31/2002, you must have been awarded:
0001 to 4565	At least 34 hours of Category I, AMA-, AOA-, or APMA-approved education or the (licensed prior to 12/31/2000) equivalent education allowed by regulation.
4566 to 4753	At least 17 hours of Category I, AMA-, AOA-, or APMA-approved education or the (licensed during 2001) equivalent education allowed by regulation.

If you have CME hours awarded after December 31, 2002, they will not apply to the licensing period of 2001-02. If they are awarded after 12/31/02, they will apply to the licensing period 2003-04.

YOU MAY BE AUDITED

The board will conduct a random audit of ten percent of the license application renewals. If your license is randomly selected for audit, you will be contacted by separate letter. You will be **required** to submit copies of your certificates and other documentation that proves that you have satisfied the continuing education requirements as you have so affirmed on this renewal form. Retain your documents on file for at least four years so you can respond to audits. DO NOT SUBMIT YOUR CME DOCUMENTS WITH THIS RENEWAL.

CME STATEMENT OF COMPLIANCE

Check one:

[X] YES . . . . I hereby affirm that I have complied with the continuing medical education requirements set forth in regulations 12 AAC 40.200 - 240 for the license period 01/01/2001 through 12/31/2002.

[ ] NO . . . . . I have not met the requirements of law for continuing medical education and I am attaching a detailed explanation of the reason for my inability to obtain the required hours of CME. I understand that my license will not be renewed at this time due to this failure to obtain the CME. I will contact a representative of the Division of Occupational Licensing for assistance. Refer to 12 AAC 40.200 on page 4 attached.

[ ] NO . . . . . I am renewing my license as a RETIRED LICENSE.

I hereby certify and affirm that the information provided in this application document is true and correct.

V **Sign here** [signature] Applicant's Signature — 10/25/02 Date

BEFORE YOU MAIL THIS RENEWAL APPLICATION--HAVE YOU?

- **Attached a check for fees payable to the State of Alaska?**
- **Completed all questions in the form?**
- **Attached explanations for any 'yes' responses?**
- **Signed the renewal form?**

All regulations referenced in this application document may be found on page 4 of the renewal form.

PUBLIC INFORMATION: All information on this renewal form will be available to the public unless required to be kept confidential by law.

WARNING: The medical board may deny, suspend, or revoke the license of a person who has obtained or attempted to obtain a license to practice by fraud or deceit. The person may also be subject to criminal charges for perjury or unsworn falsification. (AS 11.56.210 and AS 11.56.230)

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DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

SELECTED PERTINENT REGULATIONS

12 AAC 40.025. LAPSED PHYSICIAN LICENSES. (a) A physician license that has been lapsed for at least 60 days but less than one year will be reinstated if the applicant

(1) submits a completed application for license reinstatement;
(2) pays the applicable biennial license renewal fee established in 12 AAC 02.250(a);
(3) submits proof of meeting the continuing medical education requirements in 12 AAC 40 200 - 12 AAC 40.220; and
(4) receives clearance from the Federation of State Medical Boards and documentation of the clearance is sent directly to the division by that federation.

(b) A physician license that has been lapsed for at least one year but less than five years will be reinstated if the applicant meets the requirements in (a) of this section and

(1) receives clearance from the federal Drug Enforcement Administration (DEA) and documentation of the clearance is sent directly to the division by the DEA;
(2) arranges for verification of licensure to be sent directly to the division from each state other than Alaska where the applicant is or has been licensed as a physician;
(3) is qualified for a license under AS 08 64.230 and is not disqualified by AS 08.64.240; and
(4) arranges for a verification of hospital privileges to be sent directly to the division, from each hospital where the applicant has held privileges within the five years immediately before the date that the applicant signs the application form.

(c) Notwithstanding (a) and (b) of this section, the board may refuse to reinstate a physician license for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

12 AAC 40.031. ACTIVATING A RETIRED STATUS LICENSE. (a) An applicant holding a retired status license under AS 08.64.276 will, in the board's discretion, be issued an active license to practice medicine, podiatry, or osteopathy in this state, as appropriate, if the applicant

(1) submits a new and complete application as required by 12 AAC 40.010, documenting compliance with
  (A) AS 08.64.200 and 08.64.250, if a physician applicant;
  (B) AS 08.64.209 and 08.64.250, if a podiatry applicant; or
  (C) AS 08.64.205, if an osteopath applicant;
(2) submits evidence of at least 34 hours of continuing medical education credits earned within the two years immediately before the date of application,
(3) submits evidence of successful completion of the Special Purpose Examination (SPEX) prepared by the Federation of State Medical Boards;
(4) submits, at the request of the board, physical and mental examination reports from practitioners approved by the board indicating that, at the time of the examination, the applicant is mentally and physically capable of practicing medicine, podiatry, or osteopathy safely;
(5) submits information from the disciplinary data bank of the Federation of State Medical Boards;
(6) is interviewed by a member of the board; and
(7) pays the fees established in 12 AAC 02.250.

(b) If the report required in (a)(5) of this section shows evidence of disciplinary action in this state or another licensing jurisdiction within the five years immediately before the date of application under (a)(1) of this section, the board will, in its discretion, deny an application for reactivation, if the evidence demonstrates that the applicant is not capable of practicing medicine, podiatry, or osteopathy safely or lawfully.

12 AAC 40.033. INACTIVE PHYSICIAN LICENSE. (a) A physician who is not practicing in the state may hold an inactive license that may be renewed.

(b) A physician may apply for an inactive license at the time of license renewal by

(1) indicating on the form for license renewal that the physician is requesting an inactive license; and
(2) paying the inactive biennial license fee established in 12 AAC 02.250.

(c) A physician licensed as inactive may not practice as a physician in the state.

(d) A physician licensed as inactive who wishes to resume active practice as a physician in the state must

(1) meet the requirements of 12 AAC 40.025;
(2) submit a written request for reactivation;
(3) request a clearance report from the Federation of State Medical Boards Board Action Data Bank be sent directly to the board; and
(4) pay the physician biennial license renewal fee established in 12 AAC 02.250, less any inactive license fee previously paid for the same licensing period.

(e) Notwithstanding (a) and (b) of this section, the board may refuse to reactivate a physician license for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

12 AAC 40.200. GENERAL REQUIREMENTS. (a) A physician seeking renewal of a license on or after January 1, 1986 shall obtain an average of 17 credit hours of continuing medical education during each year of the previous license period.

(b) If a licensee fails to meet continuing medical education requirements due to illness or other extenuating circumstances, the licensee may request an extension of time in order to comply with those requirements. The request for an extension must be made on the licensee's application for license renewal. The board, or its designee, will only consider a request for extension if the licensee also agrees to enter into a memorandum of agreement with the board that specifies the date within the licensing period by which the licensee will meet the continuing education requirements and the licensee's agreement to voluntarily surrender the license to the board if the licensee fails to comply with the memorandum of agreement. The board, or its designee, will evaluate the request and proposed memorandum of agreement on an individual basis. If approved, the board, or its designee, will grant the extension of time and issue the renewed license for the next licensing period, effective from the date of the approval of the agreement.

12 AAC 40.210. CREDIT HOURS. (a) Except as provided in (b) of this section, a licensee may meet the continuing medical education requirements set out in 12 AAC 40.200(a) only by obtaining credit hours in a Category I continuing medical education program accredited by the American Medical Association.

(b) The board will accept the following as the equivalent of the credit hours required under 12 AAC 40.200(a):

(1) a current physician's recognition award from the American Medical Association, American Podiatry Association, American Osteopathic Association, or a recognized subspecialty board; or
(2) initial certification or recertification during the concluding licensing period by a specialty board recognized by the American Medical Association.

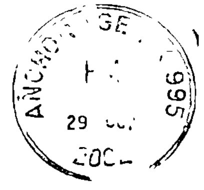
12 AAC 40.220. CERTIFICATION OF COMPLIANCE. (a) A licensee shall submit, upon a form supplied by the board, a signed statement of compliance with the continuing medical education requirement at the time the licensee applies for license renewal.

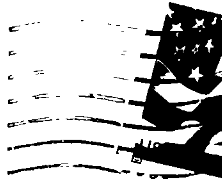
(b) The board, or its designee, will, in the board's or the board designee's discretion, require a licensee to submit additional evidence of compliance with the continuing medical education requirement. The licensee shall maintain evidence of compliance

(c) The board, or its designee, will, in the board's or the board designee's discretion, audit the statements of compliance and additional evidence submitted under (a) and (b) of this section. If upon audit, the board or its designee determines that the statement of compliance contained misstatements and that the licensee had not met continuing medical education requirements set out in 12 AAC 40.200 and 12 AAC 40 210 by the time that the statement of compliance was signed, the board or its designee will consider the licensee as securing a license through intentional misrepresentation under AS 08 64.326(a)(1). Nothing in this subsection precludes the board from finding other grounds for imposition of disciplinary sanctions under AS 08.64.326 based on the conduct described in this subsection.

12 AAC 40.240. EXEMPTION FROM CONTINUING MEDICAL EDUCATION REQUIREMENTS. For the purposes of exempting a licensee from meeting the continuing medical education requirements in a licensing period, extenuating circumstances are those circumstances, beyond the licensee's control, that prevent the licensee from meeting the continuing medical education requirements. Extenuating circumstances include the licensee's debilitating or long-term personal illness or injury and the debilitating or long-term illness or injury of a member of the licensee's immediate family.

Banks, Joey MD
16601 Virgo Ave
Anchorage AK 99516





Alaska State Medical Board - Medical License
Dept of Community & Economic Development
PO Box 110806
Juneau Alaska 99811-0806

0017

4340

State of Alaska
Department of Community and Economic Development
Division of Occupational Licensing
P.O. Box 110806
Juneau, AK 99811-0806
E-mail: license@dced.state.ak.us

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AUG 26 2002
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

CHANGE OF ADDRESS FORM

Please complete this form showing your old and new mailing address. If you would like a duplicate license reflecting the change of address, please submit a $5.00 FEE made payable to the State of Alaska. Otherwise, you may confirm that the change has been made to your record by reviewing the division's website at: www.dced.state.ak.us/occ and click on "Occupational License Search."

LICENSEE'S PROFESSION: MD

LICENSE NUMBER: AK 4340

OLD MAILING ADDRESS:
Joey Banks
Name
Alaska Family Practice Residency
Address
1201 E 36th
Address
Anchorage AK 99508
City, State, ZIP Code

NEW MAILING ADDRESS:
Joey Banks
Name
16601 Virgo Ave
Address

Address
Anchorage AK 99516
City, State, ZIP Code

done 8/29/02

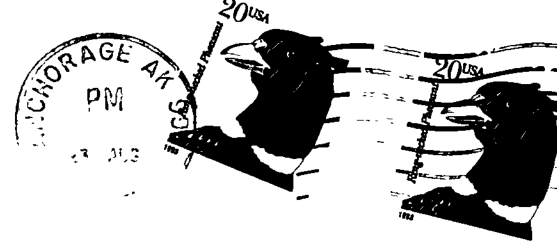
[signature]
Licensee's Signature

8/19/02
Effective Date

08-4291 (Rev. 3/02)

Banks
16601 Virgo Ave
Anchorage AK
995[illegible]

urgent - change of address before Oct



State of Alaska
Dept of Community & Economic Devel.
Division of Occupation Licensing
PO Box 110806
Juneau AK 99811-0806

0019

99811+0806

No. 4340

Effective: 12/18/2000

Expires: 12/31/2002

STATE OF ALASKA

DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT

Division of Occupational Licensing

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

STATE MEDICAL BOARD

Certifies that

JOEY MICHELE BANKS

IS A LICENSED

PHYSICIAN

Commissioner: Deborah B. Sedwick

Wallet Card

No. 4340

State Of Alaska

Department of Community and Economic Development

Division Of Occupational Licensing

This Certifies that

JOEY MICHELE BANKS

IS A LICENSED

PHYSICIAN

Effective	Expiration	Date of Birth
12/18/2000	12/31/2002	

Signature ______________________

IT IS YOUR RESPONSIBLITY TO BE AWARE OF THE CONTINUING EDUCATION REQUIREMENTS FOR RENEWAL.

WALL CERTIFICATES SUITABLE FOR FRAMING ARE AVAILABLE FOR A FEE OF $20.

THE FEE FOR VERIFICATIONS OF LICENSURE OR LETTERS OF GOOD STANDING IS $20.

PER 12 AAC 02.900 YOU MUST NOTIFY US IN WRITING IF YOU CHANGE YOUR MAILING ADDRESS. YOU MAY FAX YOUR ADDRESS CHANGE TO (907) 465-2974.

JOEY MICHELE BANKS
1201 E 36TH AVE
ANCHORAGE AK 99508

MED

553376 4340

ALASKA STATE MEDICAL BOARD

Dept. Of Community & Economic Development
Division of Occupational Licensing
P. O. Box 110806 Juneau AK 99811-0806
(907) 465-2541 - Office
E-mail: license@dced.state.ak.us

MED
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DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

MED S 4340
JOEY MICHELE BANKS
3546 LATOUCHE ST
ANCHORAGE AK 99508

MEDICAL LICENSE (MD, DO, DPM) RENEWAL APPLICATION

For the period of January 1, 2001 thru December 31, 2002

INSTRUCTIONS - Please read carefully.

Your license to practice medicine in Alaska lapses December 31, 2000. It is illegal for you to practice if your license is lapsed. There is no grace period. To renew your license for the coming license period, please return this signed application to the above address with a check or money order payable to the State of Alaska. **This is the only renewal notice you will receive.** Your renewal will be rejected if the form is incomplete or insufficient fees are received. If you wish to receive confirmation that the board has received your renewal, mail it certified, return receipt requested. Numerous telephone calls delay processing. Receipt of the renewal form does not mean processing is complete or that a renewed license has been issued.

RENEWAL DUE DATE — **For processing prior to December 31, 2000, your renewal must be received in our office no later than December 1, 2000.** Processing of a complete renewal takes three to four weeks from the date of receipt in our office--Plan accordingly.

NAME CHANGE — If you have had a legal name change since your last license was issued, enclose a certified true copy of the legal document (marriage certificate, divorce decree, etc.) as proof of the change.

SOCIAL SECURITY NUMBERS — In accordance with AS 08.01.100(b), the department is not authorized to renew a license unless the licensee's social security number has been provided to the department.

EXPIRED LICENSES — If you choose not to renew your license before it lapses, you may renew the license at a later date only after meeting the requirements of regulation 12 AAC 40.025. Licenses that are lapsed for more than five years may not be renewed.

INACTIVE LICENSES — You may not practice medicine (including writing prescriptions) in Alaska on an inactive license.

RETIRED LICENSES — There is a one-time fee for the remainder of the licensee's lifetime. A physician may not practice medicine on a retired license, nor is there a requirement to meet CME under a retired license. BEFORE YOU RETIRE YOUR LICENSE, please carefully review 12 AAC 40.031 regarding reactivation requirements that are included in this renewal.

PAYMENT OF CHILD SUPPORT OR STUDENT LOANS — If the Alaska Child Support Enforcement Division has determined you are in arrears on child support, or if the Alaska Commission on Post-Secondary Education has determined you are in loan default, you will be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Enforcement at 800/478-3300 or 907/269-6659 or Post-secondary Education at 888/441-2962 or 907/269-6659 to resolve payment issues.

PUBLIC INFORMATION — All information on this renewal form will be available to the public unless required to be kept confidential by law.

Check appropriate box: [X] **ACTIVE LICENSE $590** [ ] **INACTIVE LICENSE $250** [ ] **RETIRED LICENSE $100**

PERSONAL INFORMATION: (PRINT LEGIBLY OR TYPE)

LAST NAME	FIRST	MIDDLE	SEX
Banks	Joey	Michele	[X] F [ ] M
SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YY)	ALASKA LICENSE NUMBER	
[redacted]	[redacted]	~~1059~~ 4340	

MAILING ADDRESS* — *Is this an address change? [ ] No [X] Yes OK

STATE ZIP

PRIMARY PRACTICE AD[DRESS]

STATE ZIP

TELEPHONE – DAY

AREA CODE

ADDRESS CHANGE:
1201 E 36th Avenue
Anchorage, AK 99508
907-562-9229

GENERAL INFORMATION:

PRACTICE SPECIALTY: Family Practice SUBSPECIALTY: ____________

LIST ALL OTHER STATES AND/OR PROVINCES OF CANADA OR OTHER JURISDICTIONS IN WHICH YOU HOLD OR HAVE EVER HELD A LICENSE TO PRACTICE MEDICINE ____________

PROFESSIONAL CONDUCT:

The following 12 questions must be answered. "Yes" answers do not automatically result in license denial. If you answer "Yes" to any question, attach a detailed explanation including dates and circumstances. Attach copies of supporting documents that are applicable (court records, copies of actions, etc.). **Failure to attach a detailed explanation will result in the application being rejected. Please read each question carefully. Please check the appropriate response to the questions below.**

CONFIDENTIALITY:

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

1 ☒ NO ☐ YES Has your professional license ever been denied, revoked, suspended, surrendered, stipulated, placed on probation, reprimanded, or been otherwise restricted or disciplined in any jurisdiction, including military authorities?

If you answer "Yes" to the above question, provide the following:
Name of Jurisdiction in Which Action was Taken: ____________
Date of the Action: ____________

2 ☐ NO ☐ YES If you answered "Yes" to the question above, have you previously reported this action to the State of Alaska Division of Occupational Licensing or the Alaska State Medical Board?

Since the date of your last application for a license to practice medicine in Alaska, or within the past two years:

3 ☒ NO ☐ YES Have you voluntarily surrendered or restricted your professional license in any jurisdiction?

4 ☒ NO ☐ YES Have your staff privileges been denied, reduced, restricted, removed, or otherwise disciplined by any hospital, clinic, or other health care organization (OTHER THAN LATE MEDICAL RECORDS)?

5 ☒ NO ☐ YES Have you been convicted of a felony or misdemeanor, other than minor traffic violations, under the laws of any local, state, or federal jurisdiction of the United States or any other country?

6 ☒ NO ☐ YES Have you been the subject of an investigation by any licensing jurisdiction or are you currently under investigation by any licensing jurisdiction?

7 ☒ NO ☐ YES Have you withdrawn an application for a license from a state licensing agency or for privileges from a hospital while under investigation?

8 ☒ NO ☐ YES Have you experienced, been diagnosed with, or been treated for any alcohol or other chemical impairment?

9 ☒ NO ☐ YES Have you experienced, been diagnosed with, or been treated for any physical or mental condition which may impair or interfere with your ability to practice?

10 ☒ NO ☐ YES Have you experienced, been diagnosed with, or treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder?

(Questions Continued on Next Page)

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DEC 1 1 2000
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

4340

11 [X] NO [ ] YES Has a medical malpractice claim been resolved or a civil action been terminated in which damages have been paid, or are to be paid, by you, or on your behalf to a claimant or plaintiff, whether by judgment or under settlement?

12 [X] NO [ ] YES Have you been investigated by the Drug Enforcement Administration or have you surrendered your federal or any state controlled substance registration for any reason?

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OCCUPATIONAL LICENSING
JUNEAU

CONTINUING MEDICAL EDUCATION

As provided by regulations 12 AAC 40.200, 210, 220, and 240, your license cannot be renewed unless you have met continuing medical education requirements. Those regulations are provided on page 4 of this application. Individuals who are renewing their licenses in "Retired" status are not required to complete CME.

YOU MAY BE AUDITED

The board will conduct a random audit of ten percent of the license application renewals. If your license is randomly selected for audit, you will be sent a letter. You will be **required** to submit copies of your certificates and other documentation that proves that you have satisfied the continuing education requirements as you have so affirmed on this renewal form. Retain your documents on file for at least four years so you can respond to audits. DO NOT SUBMIT YOUR CME DOCUMENTS WITH THIS RENEWAL.

If your license number is:	You must have obtained:
0001 to 4177	At least 34 hours of Category I, AMA-, AOA-, or APMA-approved education or the equivalent education allowed by regulation.
4178 to 4393	At least 17 hours of Category I, AMA-, AOA-, or APMA-approved education or the equivalent education allowed by regulation.

CME STATEMENT OF COMPLIANCE

I hereby affirm that I have complied with the continuing medical education requirements set forth in regulations 12 AAC 40.200 - 240 for the license period of January 1, 1999 through December 31, 2000.

✔ *Check one:* [X] **YES** [ ] **NO*** [ ] **NO - RETIRED LICENSE**

*If you check "NO", attach a detailed explanation of the reason for your inability to obtain the required hours of CME. Failure to obtain the required CME hours will result in your license not being renewed at this time. You will be contacted by a representative of the Division of Occupational Licensing who will assist you.

I hereby certify and affirm that all information provided in this application document is true and correct.

✔ *Sign here:* [signature] Applicant's Signature 11/8/00 Date

PUBLIC INFORMATION: All information on this renewal form will be available to the public unless required to be kept confidential by law.

WARNING: The medical board may deny, suspend, or revoke the license of a person who has obtained or attempted to obtain a license to practice by fraud or deceit. The person may also be subject to criminal charges for perjury or unsworn falsification. (AS 11.56.210 and AS 11.56.230)

NOTIFICATION OF PROPOSED REGULATIONS CHANGES
If you would like to receive notice of all proposed medical regulation changes, please send a written request adding your name to the "Medical" Interested Parties List to:
REGULATIONS SPECIALIST
Dept. of Community and Economic Development - Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806

Tony Knowles, Governor

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/

Date: 11-30-00

Joey Banks, MD
1201 E. 36th Ave
Anchorage, AK 99508

Dear Licensee:

We have received your renewal for the licensing period of January 1, 2001 through December 31, 2002. It is incomplete for the reason(s) indicated. The following items must be completed in order for your MD, DO, or DPM license to be renewed:

_____ 1. License fee: $590 Active; $250 Inactive (if you do not plan to practice in Alaska).

_____ 2. Answer General Information question on page 2.

_____ 3. Answer the Professional Conduct question(s).

_____ 4. You answered "Yes" to the Professional Conduct question(s) ________. Please attach an explanation.

X 5. Complete the Continuing Medical Education (CME) Statement of Compliance on page 3.

_____ 6. Sign and date your renewal form on page 3.

_____ 7. Sign and date your renewal again upon completion.

_____ 8. Other: ____

IMPORTANT:

All current licenses lapse December 31, 2000. To activate licenses lapsed more than 60 days, but less than one year, the licensee will need to also submit:

1. Copies of Continuing Medical Education Category 1 for 1999 and 2000 (an average of 17 credit hours for each year for a total of 34).
2. Board Action Data Bank Search from Federation of State Medical Boards of the United States, Inc.

Sincerely, J Stude

JOANIE STUDE
LICENSING EXAMINER
STATE MEDICAL BOARD

JS/dgl/8049js.doc
111500a

No. 4340

Effective: 11/15/1999

Expires: 12/31/2000

STATE OF ALASKA

DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT

Division of Occupational Licensing

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

STATE MEDICAL BOARD

Certifies that

JOEY MICHELE BANKS

IS A LICENSED

PHYSICIAN

Commissioner: Deborah B. Sedwick

Wallet Card

No. 4340

State Of Alaska

Department of Community and Economic Development

Division Of Occupational Licensing

This Certifies that

JOEY MICHELE BANKS

IS A LICENSED

PHYSICIAN

Effective	Expiration	Date of Birth
11/15/1999	12/31/2000	[redacted]

Signature ____________________

CONGRATULATIONS, YOUR APPLICATION FOR LICENSURE WAS APPROVED BY THE MEDICAL BOARD AT ITS 10/21-22/99 MEETING. IT IS YOUR RESPONSIBLITY TO BE AWARE OF THE CONTINUING EDUCATION REQUIREMENTS FOR RENEWAL.

WALL CERTIFICATES SUITABLE FOR FRAMING ARE AVAILABLE FOR A FEE OF $20.

OUR FEE FOR VERIFICATIONS OF LICENSURE OR LETTERS OF GOOD STANDING IS $20.

PER 12 AAC 02.900 YOU MUST NOTIFY US IN WRITING IF YOU CHANGE YOUR MAILING ADDRESS. YOU MAY FAX YOUR ADDRESS CHANGE TO (907)465-2974.

JOEY MICHELE BANKS
ALASKA FAMILY PRACTICE RESIDENCY
3546 LATOUCHE STREET
ANCHORAGE AK 99508

MED

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
P.O. BOX 110806, JUNEAU, ALASKA 99811-0806
TELEPHONE: (907) 465-2541

Date 9/17/99

Dear Dr. Banks

Your application for licensure to practice medicine and surgery in the State of Alaska has been received by this office. Alaska Statute 08.64.255 was amended, effective August 7, 1996, which changes the in-person interview from mandatory to optional.

_______ Your file has been forwarded for further review to Leslie Abel, Executive Administrator, at (907) 269-8163. Processing is continuing.

___✓___ Your file is complete and will be reviewed at the next board meeting which is scheduled for 10/21 & 22/99. I will issue you a temporary permit upon approval by Leslie Abel, Executive Administrator.

_______ Your file is incomplete and you will be required to submit the following for your application to be reviewed at the next board meeting tentatively scheduled for ________________.

_______ 1. Completed Application ________________

_______ 2. Biographical Data Sheet.

_______ 3. Application fee of $200. We received $________. Please remit remaining fee of $________.

_______ 4. Our license fee has increased to $340 or $85 now and $255 once the board has approved your application for licensure. We received $________. Please remit remaining fee of $________.

_______ 5. Complete authorization to release records form.

_______ 6. Examination scores requested directly from: FLEX ________ NBME ________ USMLE ________. State of ________ Puerto Rico ________ LLMC ________ NBOME ________ NBPME ________.

_______ 7. Certified true copy of your medical school diploma (notary public must state "true copy of original," sign and seal) or transcript or original letter on letterhead.

_______ 8. Certified true copy of all internship and residence certificates (notary public must state "true copy of original," sign and seal) or original letter on letterhead from the program.

_______ 9. We have not received a response from: Medical school ________ Postgraduate year one ________

_______ 10. Verification of license(s) in ________________

_______ 11. Hospital privileges information needed from ________________

_______ 12. AMA Profile, DEA, Federation Clearances.

_______ 13. Tentative start date in Alaska if known ________________

Additional Comments: ________________

I have requested a response from NPDB. If you have any questions, please do not hesitate to contact this office.

Sincerely,

Nancy Ferguson
Licensing Examiner
State Medical Board

0026

08-4242 (Rev. 12/98)

Alaska Family Practice Residency

9/14

Nancy - I believe this is the last of documents needed.

Is there any way to get a temporary License until the Board meets?

Roni Macy
907-273-9331

RECEIVED
SEP 15 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

Providence Alaska Medica

Anchorage, Alaska

This Certifies That

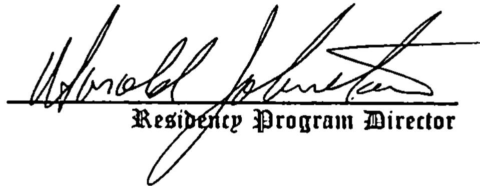
Joey Michele Banks, M.D.

has faithfully and satisfactorily performed the

First Year Family Practice Residen

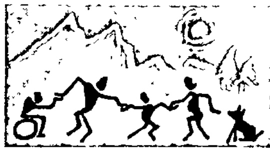
From June 30, 1998 to June 27, 1999

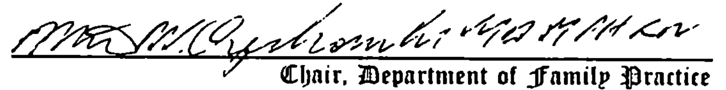
In witness whereof, the undersigned have affixed th



Residency Program Director

Chief of Medi





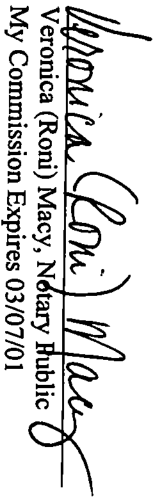
Chair, Department of Family Practice

An Alaska WWAMI/University of Washington Affiliated Progr

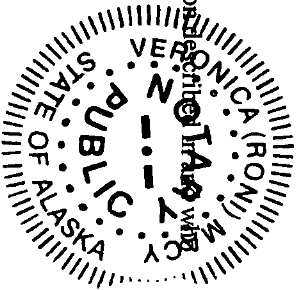
STATE OF ALASKA
THIRD JUDICIAL DISTRICT

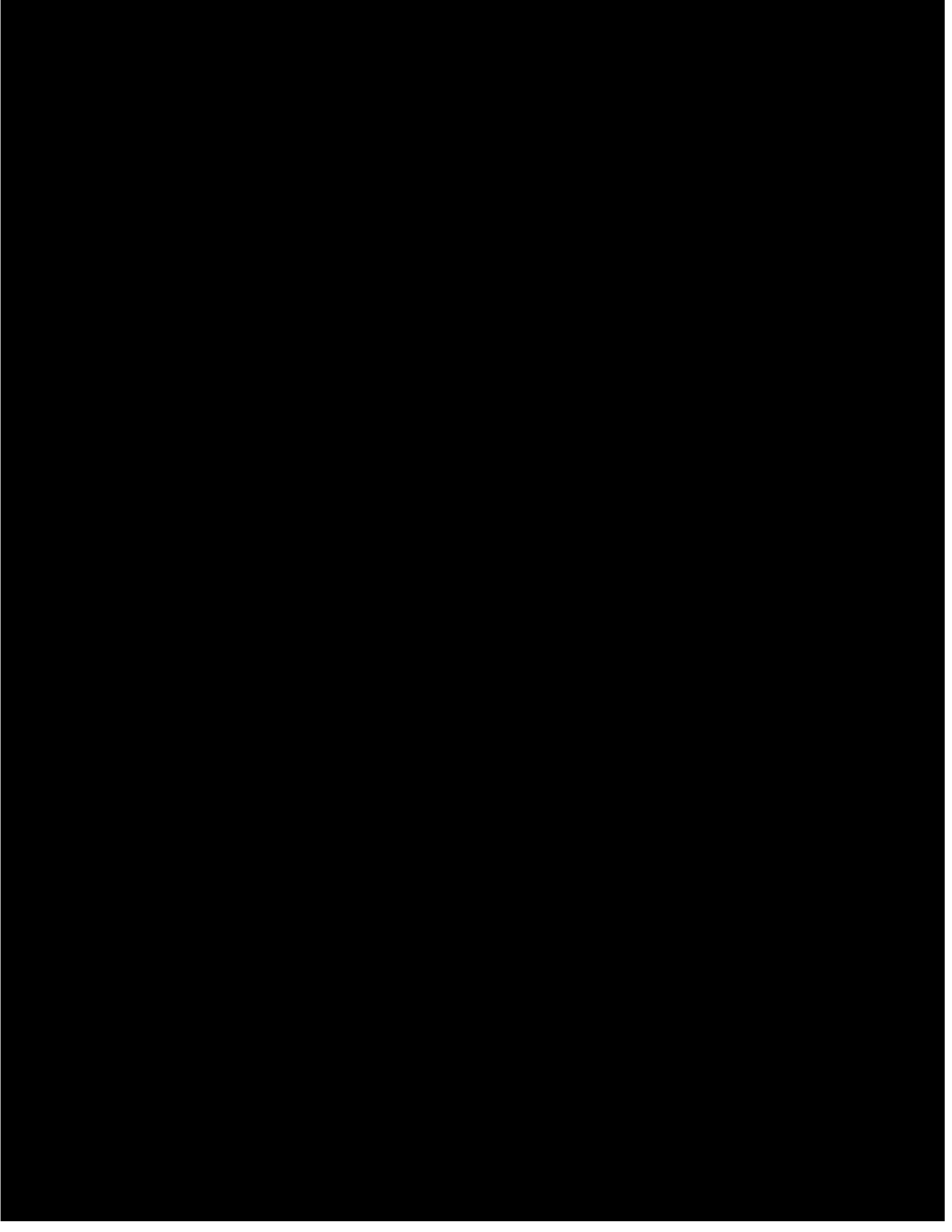
On this 3rd day of September, 1999, before me personally appeared Joey Banks, MD known to me to be the person described in and who executed the within instrument and acknowledged to me that she executed the same.

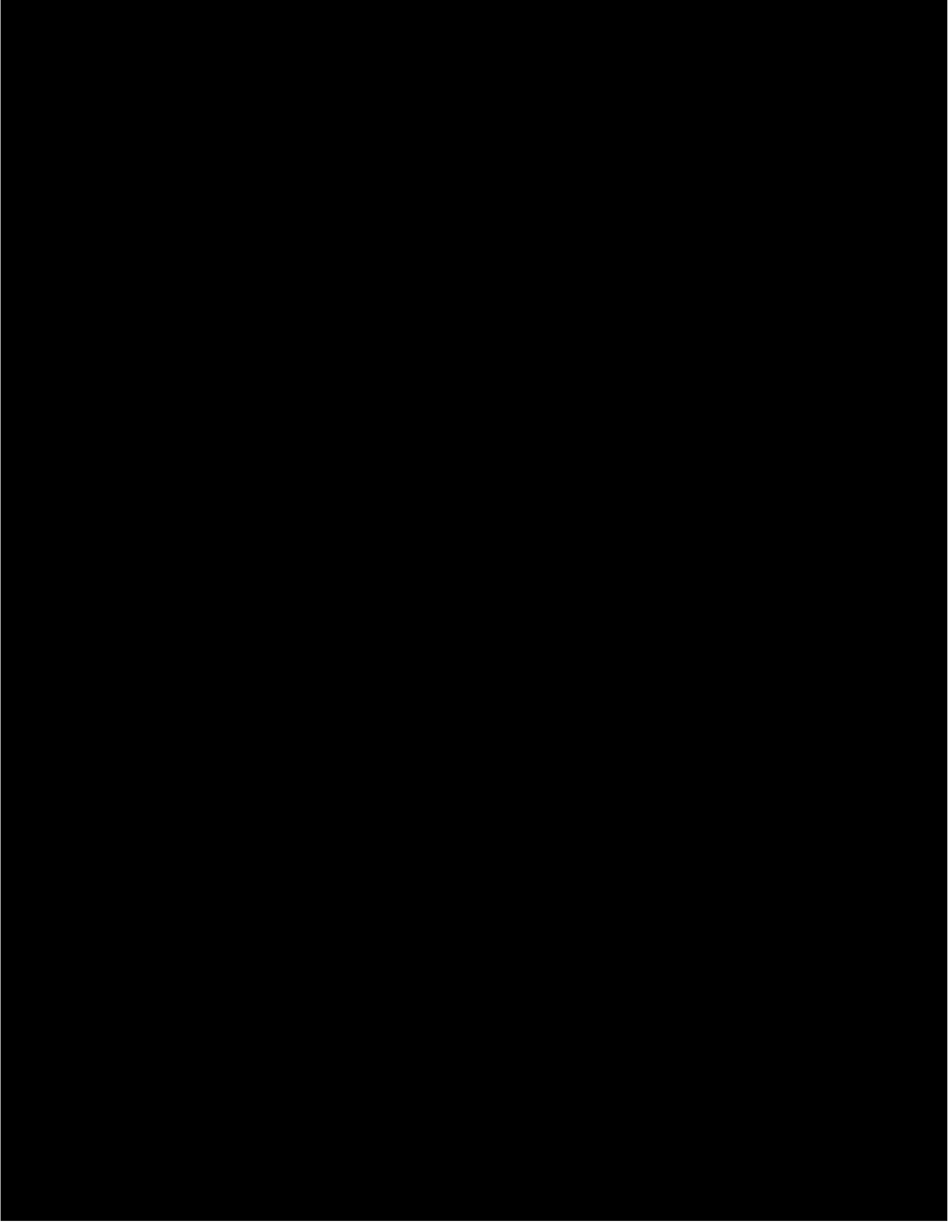
Joey Banks, MD

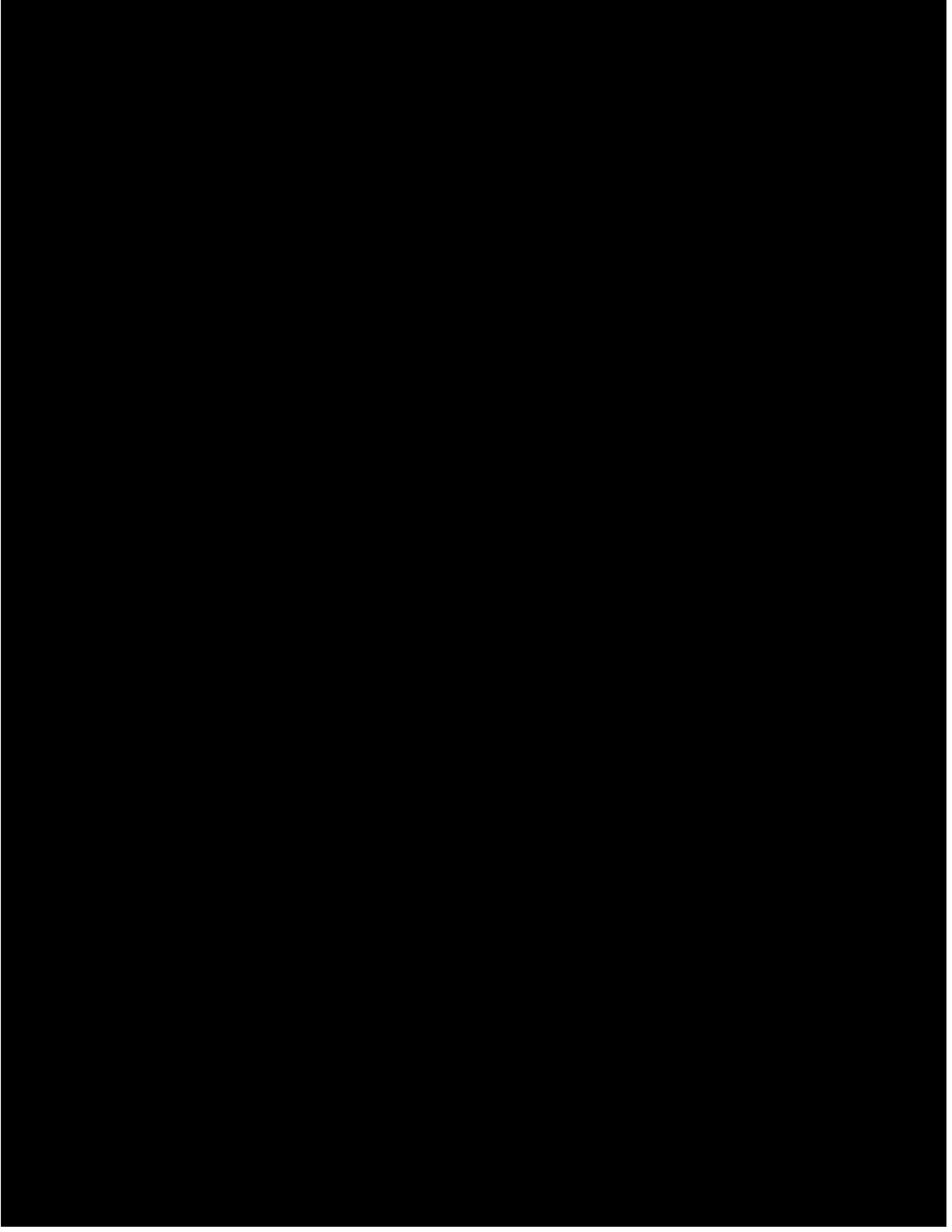


Veronica (Roni) Macy, Notary Public
My Commission Expires 03/07/01









Authenticity of USMLE™ Transcripts

Original, certified transcripts of United States Medical Licensing Examination (USMLE) scores are printed on blue safety paper and are produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The embossed USMLE seal 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.

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 recent administrations, the mean and standard deviation of scores on the three-digit scale for first-time examinees from medical schools in the United States are approximately 205 and 20, respectively, and most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 82 on the two-digit scale is equivalent to a score of 200 on the three-digit scale. A score of 75 on the two-digit scale is always the 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 Step of USMLE 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 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 6 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

NOTATION REGARDING FSMB BOARD ACTION DATA BANK

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 <u>not</u> disciplinary or otherwise prejudicial in nature. Such actions are reported to assure 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.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Special circumstances in connection with the administration of an examination may result in one of the following annotations being listed next to the score for that examination:

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, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

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

Irregular Behavior - The USMLE 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.* To obtain information regarding the nature of the irregular behavior, the full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

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.

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

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
P.O. BOX 110806, JUNEAU, ALASKA 99811-0806
TELEPHONE: (907) 465-2541

Date 7/28/99

Dear Dr. Banks

Your application for licensure to practice medicine and surgery in the State of Alaska has been received by this office. Alaska Statute 08.64.255 was amended, effective August 7, 1996, which changes the in-person interview from mandatory to optional.

_____ Your file has been forwarded for further review to Leslie Abel, Executive Administrator, at (907) 269-8163. Processing is continuing.

_____ Your file is complete and will be reviewed at the next board meeting which is scheduled for _____. I will issue you a temporary permit upon approval by Leslie Abel, Executive Administrator.

✓ Your file is incomplete and you will be required to submit the following for your application to be reviewed at the next board meeting tentatively scheduled for 10/21 & 22/99.

_____ 1. Completed Application _____

_____ 2. Biographical Data Sheet.

_____ 3. Application fee of $200. We received $_____. Please remit remaining fee of $_____.

_____ 4. Our license fee has increased to $340 or $85 now and $255 once the board has approved your application for licensure. We received $_____. Please remit remaining fee of $_____.

_____ 5. Complete authorization to release records form.

(NV) ✓ 6. Examination scores requested directly from: FLEX _____ NBME _____ USMLE ✓
State of _____ Puerto Rico _____ LLMC _____ NBOME _____ NBPME _____.

(OK) ✓ 7. Certified true copy of your medical school diploma (notary public must state "true copy of original," sign and seal) or transcript or original letter on letterhead.

✓ 8. Certified true copy of (all) internship and residence certificates (notary public must state "true copy of original," sign and seal) or original letter on letterhead from the program. Also letter from the program indicating anticipated completion date.

_____ 9. We have not received a response from: Medical school _____ Postgraduate year one _____

_____ 10. Verification of license(s) in _____

_____ 11. Hospital privileges information needed from _____

(NV) ✓ 12. ~~AMA Profile, DEA~~, Federation Clearances.

_____ 13. Tentative start date in Alaska if known _____

Additional Comments: _____

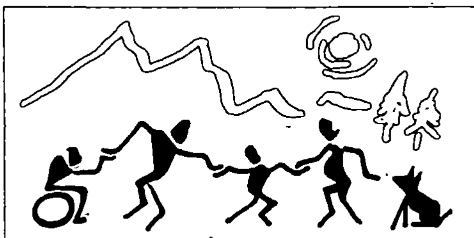
I have requested a response from NPDB. If you have any questions, please do not hesitate to contact this office.

Sincerely,

Nancy Ferguson

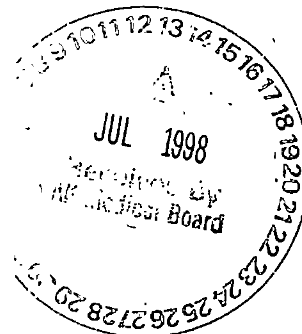
Nancy Ferguson
Licensing Examiner
State Medical Board

08-4242 (Rev. 12/98)



ALASKA FAMILY PRACTICE RESIDENCY

3546 LaTouche Street Anchorage, Alaska 99508
907-561-4500 phone
907-561-4806 fax



July 10, 1998

Leslie G. Abel
Executive Administrator
Division of Occupational Licensing
State of Alaska
3601 C Street - Suite 722
Anchorage, AK 99503

Re: Joey M. Banks, MD
SSN: [redacted]
Date of Birth: [redacted]

Dear Ms. Abel:

This is written notification of my change of address for the State of Alaska Occupational Licensing records. Please revise my record to reflect the following address:

Joey M. Banks, MD
C/O Alaska Family Practice Residency
3546 La Touche Street
Anchorage, AK 99508
Phone (907) 561-4500

If you have any questions, or require additional information please contact me at this address.

Thank you,

Joey Banks MD

Joey M. Banks, MD
Resident

/rm

Author: Nancy Ferguson at dced_jun1
Date: 7/10/98 9:14 AM
Priority: Normal
TO: Leslie Abel at DCED_FRONT
Subject: Re[2]: Ronnie AK Res Program

---------------------------------- Message Contents ----------------------------------

It turns out that I have [redacted] NBME exam scores here. Will hold onto them since you will be forwarding her file next week.

Thanks for taking care of the new first year folks, and those 2nd year people also. I would have really been in panic mode last week if it weren't for your help on those. Thanks!

______________________________ Reply Separator ______________________________

Subject: Re: Ronnie AK Res Program
Author: Leslie Abel at DCED_FRONT
Date: 7/10/98 8:46 AM

I talked with Miriam about this a half hour ago.

I spent three hours working with Roni a couple months ago going over license application processes. I have spent quite a lot of time trying to educate her and keep on top of her residents for her (which as you know, I normally would not do). I think Roni dropped the ball somewhat on this applicant and is now in a panic. [redacted] app was delivered to me on June 29. I have not yet reviewed it but will do so today along with all the other docs in the program to finalize the app processing.

I will be sending these files to you in the pouch on Tuesday and will get out of the processing business! (I only did these as a courtesy to Roni since you were out on vacation.)

Thanks for the note.

______________________________ Reply Separator ______________________________

Subject: Ronnie AK Res Program
Author: Nancy Ferguson at dced_jun1
Date: 7/9/98 4:03 PM

Ronnie called about 3:40 looking for a permit for a 2nd year resident named [redacted] Apparently [redacted] filled the slot vacated by [redacted] However I checked and I have not received anything from you regarding issuance of a resident permit for her. I told Ronnie that I need approval from you in order to issue, and I do not have the file here, so nothing could be done until you return to the office Friday. Ronnie's #273-9331.

Author: Leslie Abel at DCED_FRONT
Date: 7/16/98 11:09 AM
Priority: Normal
Receipt Requested
TO: Catherine Reardon at DCED_JUN1
TO: Nancy Ferguson at DCED_JUN1
TO: Judy Weske at DCED_JUN1
Subject: App Processing

---------------------------------- Message Contents ----------------------------------

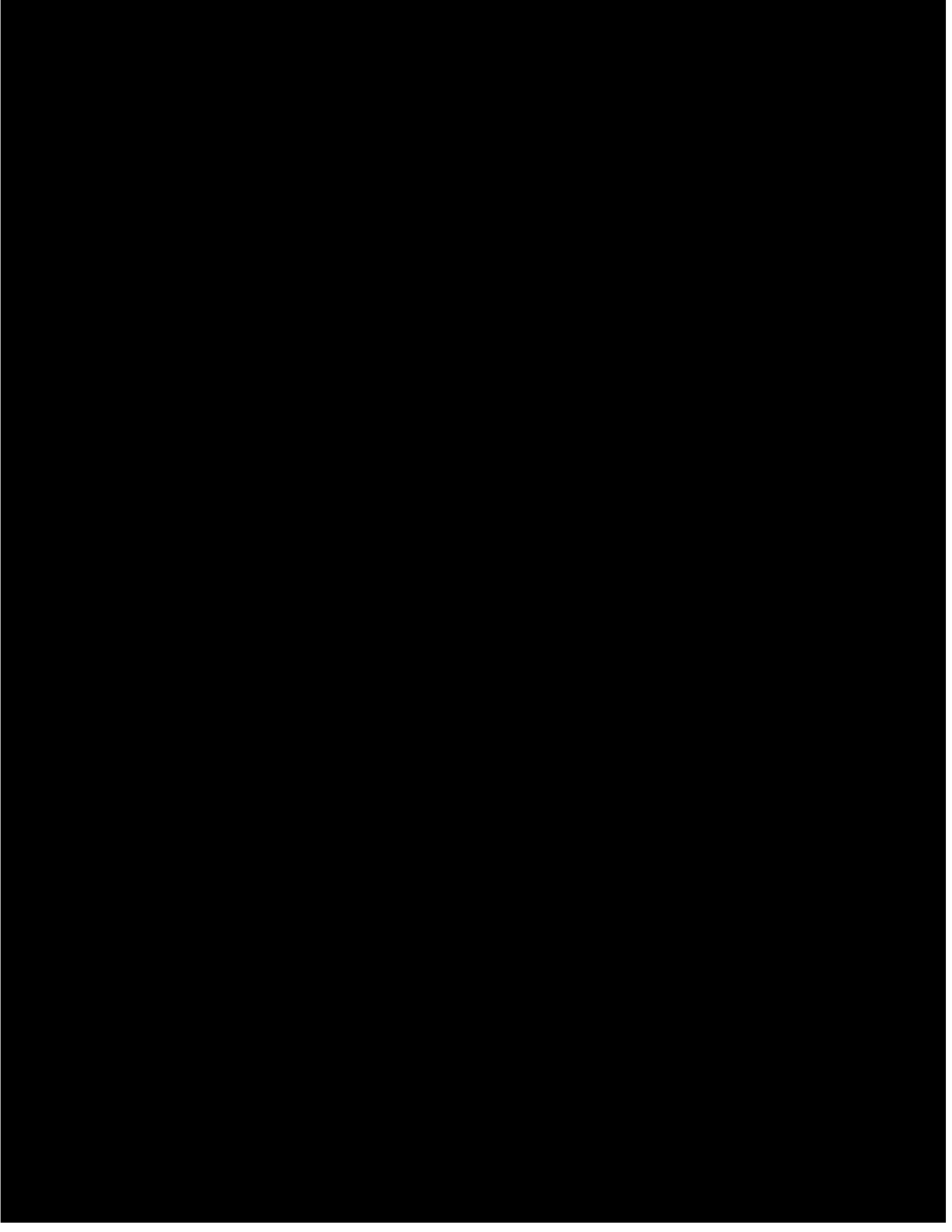
You may receive a call from someone at the Alaska Family Practice Residency Program. There were a couple residents whose apps were received in my office 6/29. By the time I could review and approve for permits, it was 7/10. They started working the residents 7/1 and did not call me to follow up on the permits.

I called the administrator's office numerous times and left messages and received only one call back from her.

I had met w/ the administrator many weeks ago and discussed at length the licensing process and the need for them (at the program) to stay on top of the documents and the apps.

Roni Macy called me today and was upset because a couple of the permits were not issued until 7/10. I explained that it was just because of the workload I have and the numerous callers and drop-ins that I see that I was unable to process sooner. She is not particularly happy with that response.

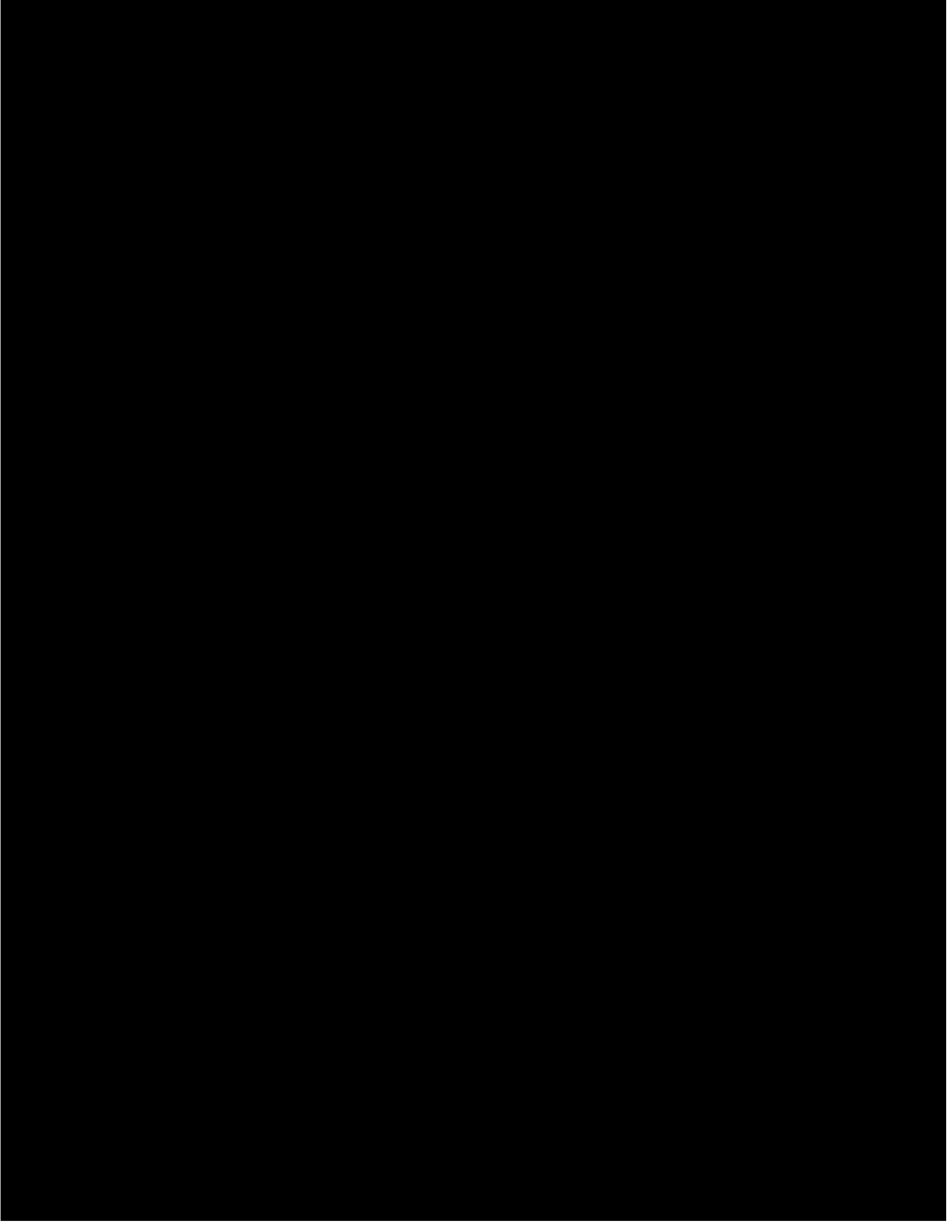
You may or may not hear from either her or [redacted] about this but thought I'd let you know in advance just in case.
Leslie



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.



AMA Physician Profile (continued)

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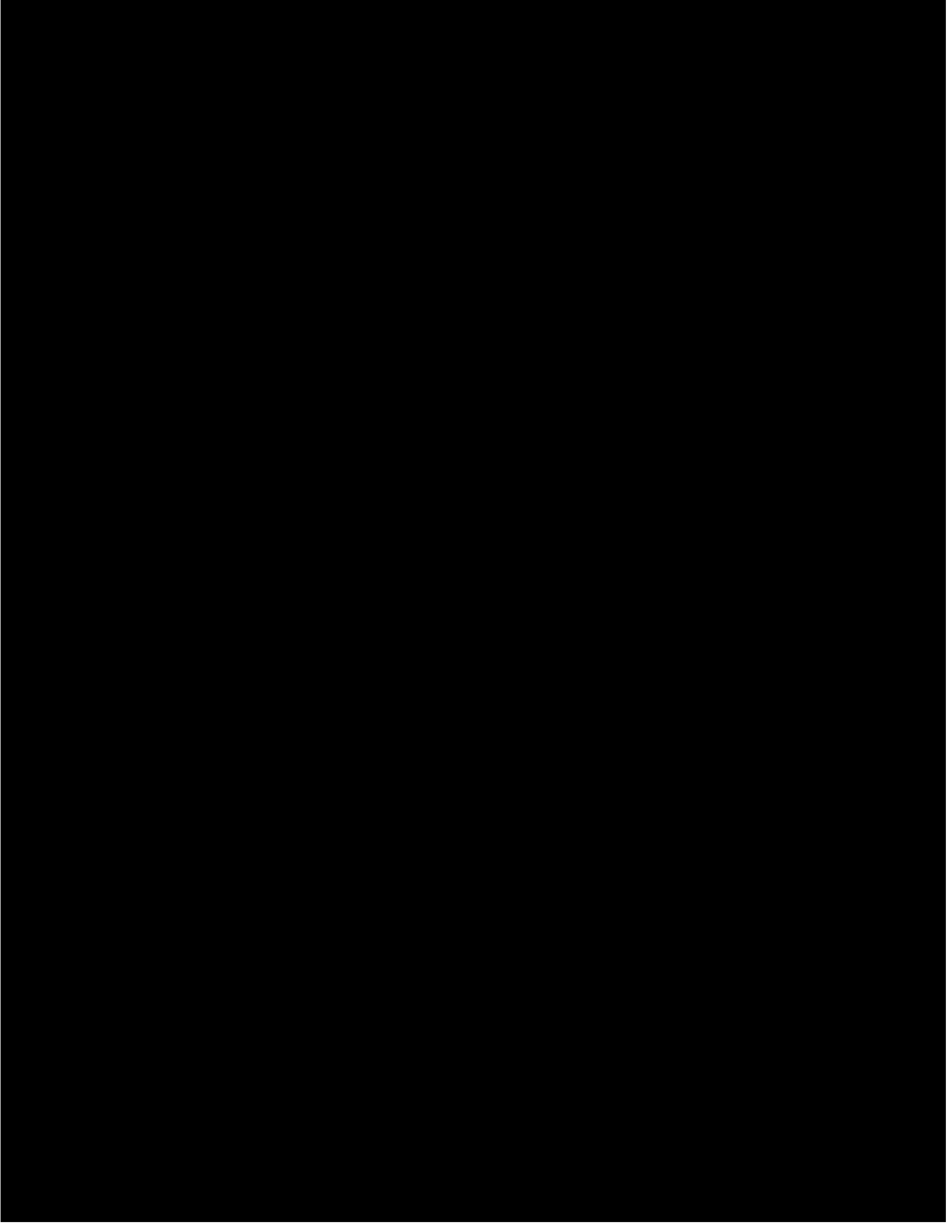

AMA Physician Profile (continued)

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PGY 1

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
333 WILLOUGHBY AVENUE, NINTH FLOOR
P.O. BOX 110806, JUNEAU, ALASKA 99811-0806
(907) 465-2541

FOR OFFICE USE
DATE
RECEIVED
JUN 22 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

I am applying for a license to practice medicine and surgery in the State of Alaska. The State Medical Board requires independent verification of my completion of postgraduate year 1. Please complete this form and return it directly to the address above. Please consider my signature below as authorization to honor such request. Thank you for your assistance.

RE: Name: Joey Michele Banks (MD)/DO

Maiden Name or Other Names Used: Journeycake

Date of Birth: [redacted] Social Security Number: [redacted]

[signature]
Signature of Physician/Applicant

PLEASE DO NOT DETACH

(Below to be completed by Internship Program Supervisor)

Medical School: Indiana University Medical School

Exact Date on Medical School Diploma: 5/10/98

Internship/PGY1 Completed at: Alaska Family Practice Residency

Dates From: June 22, 1998 To: June 28, 1999

During his/her postgraduate training, was he/she ever investigated or disciplined by the program (such discipline may include being placed on probation, issued a letter of reprimand, censure, suspended from the program, restricted, etc.)?

☐ Yes ☒ No

If Yes, please explain: ______

If Yes, please give nature and length of probation: ______

(SEAL)
(if applicable)

Signed: [signature]

Title: Program Director

Program: Alaska Family Practice Residency

Date: April 5, 1999

08-4105k (Rev. 4/97)

ALASKA
Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT

RECEIVED
JUN 22 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

VERIFICATION OF GOOD STANDING
RESIDENCY TRAINING PROGRAM

RESIDENT-IN-TRAINING:

Joey Michele Banks
Name of Resident Physician

RESIDENCY TRAINING PROGRAM:

ALASKA FAMILY PRACTICE RESIDENCY
Name of Program

3546 LaTouche Street
Address of Program

Anchorage, Alaska		99508	(907)561-4500
City	State	Zip Code	Phone No.

RESIDENCY ROTATION TO BE SERVED AT:

PROVIDENCE ALASKA MEDICAL CENTER
Name of Alaskan Facility, Hospital, Clinic City

June 28, 1999 thru June 30, 2002
Dates of Rotation

I CERTIFY that the Resident Physician named above is a resident in good standing at the residency program shown above. This physician will be serving a portion of his/her clinical training at the Alaska institution as indicated. This program is approved by the Council on Medical Education of the American Medical Association or the Canadian Medical Association.

Harold Johnston
Signature, Director of the Residency Program

Harold L. Johnston, MD
Printed Name

April 5, 1999
Date

08-4022 c (Rev 10/97)

RESIDENT

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
P.O. BOX 110806
JUNEAU, ALASKA 99811-0806
(907) 465-2541

RECEIVED
JUN 22 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

Date: 6/10/99

Dear Dr. Banks:

Your application for residency permit to allow you to practice medicine and surgery in the State of Alaska has been received by this office. Alaska Statute 08.64.255 was amended, effective August 7, 1996, which changes the in-person interview from mandatory to optional. This office will not guarantee processing of last minute request for resident permits.

____ Your file is complete and has been approved for the resident permit. I show your start date is ________. I will mail your permit on ________.

____ Your file has been forwarded for further review to Leslie Abel, Executive Administrator, at (907) 269-8163. Processing is continuing.

✓ Your file is incomplete and you will be required to submit the following:

____ 1. Complete application ________

____ 2. Biographical Data Sheet

____ 3. Authorization to Release Records Form

____ 4. Certified true copy of your medical school diploma (notary must state "true copy of original," sign and seal) or official transcripts or original letter on letterhead from the school

✓ 5. Letter from your internship or residency program *form completed & signed by Dr Johnston*

✓ 6. Letter from Alaska institution accepting responsibility for training *form completed & signed by Dr Johnston.*

____ 7. Residency application fee of $30.00

____ 8. Residency permit fee of $20.00

Additional Comments: *Permit expires 7/7/99*

Attached

The next written correspondence you will receive will be sent once your file becomes complete.

Please remember it is your responsibility to keep this office advised of your current mailing address at all times.

If you have any questions, please do not hesitate to contact this office.

Sincerely,

Nancy Ferguson
Licensing Examiner
State Medical Board

cc: Roni Macy
Residency Coordinator
FAX

Thank You!

08-676 (Rev. 3/99)

ALASKA FAMILY PRACTICE RESIDENCY

3546 LaTouche Street Anchorage, Alaska 99508
907-561-4500 phone
907-561-4806 fax

RECEIVED
JUN 22 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

May 13, 1999

Alaska Department of Commerce & Economic Development
Division of Occupational Licensing
PO Box 110806
Juneau, AK 99811-0806

Re: Joey Michele Banks, MD
DOB: [redacted]
SSN: [redacted]
Indiana University Medical School, 05/10/98

To Whom It May Concern:

Joey Banks is in good standing in the Alaska Family Practice Residency owned by Providence Alaska Medical Center. The above named individual began their training on June 22, 1998.

Sincerely,

Harold L. Johnston, MD
Program Director

/rm

MD/DO

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
333 WILLOUGHBY AVENUE, NINTH FLOOR
P.O. BOX 110806, JUNEAU, ALASKA 99811-0806
(907) 465-2541

FOR OFFICE USE ONLY
DATE

DIVISION OF OCCUPATIONAL LICENSING
RECEIVED
'99 JUN 14 PM 1 30

I am applying for a license to practice medicine and surgery in the State of Alaska. The State Medical Board requires independent verification of my completion of medical school and receipt of medical school diploma. Please complete this form and return it directly to the address above. Please consider my signature below as authorization to honor such request. Thank you for your assistance.

RE: Name: Joey Michele Banks (MD)/DO

Maiden Name or Other Names Used: Journeycake

Date of Birth: [redacted] Social Security Number: [redacted]

Signature of Physician/Applicant: [signature]

PLEASE DO NOT DETACH

(Below to be completed by MD/DO School)

Medical School: Indiana University School of Medicine

Exact Date on Medical School Diploma: 05/10/1998

During his/her medical school education, was he/she ever placed on probation, suspended, restricted, or otherwise disciplined for any reason? ☐ Yes ☒ No

If Yes, please explain: ______

During his/her medical school education, was he/she under investigation or disciplined for any reason related to the practice of medicine? (Such discipline includes having been placed on probation, issued a letter of reprimand, censured, etc.) ☐ Yes ☒ No

If Yes, please explain: ______

(SEAL)
(if applicable)

Signed: [signature] Dennis Deal

Title: Director of Academic Records

Program: Doctor of Medicine

Date: June 7, 1999

0048 NF/dgl

08-4105j (Rev. 4/97)

RESIDENT

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
P.O. BOX 110806
JUNEAU, ALASKA 99811-0806
(907) 465-2541

Date: 6/10/99

Dear Dr. Banks:

Your application for residency permit to allow you to practice medicine and surgery in the State of Alaska has been received by this office. Alaska Statute 08.64.255 was amended, effective August 7, 1996, which changes the in-person interview from mandatory to optional. This office will not guarantee processing of last minute request for resident permits.

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_____ Your file has been forwarded for further review to Leslie Abel, Executive Administrator, at (907) 269-8163. Processing is continuing.

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_____ 1. Complete application __________

_____ 2. Biographical Data Sheet

_____ 3, Authorization to Release Records Form

_____ 4. Certified true copy of your medical school diploma (notary must state "true copy of original," sign and seal) or official transcripts or original letter on letterhead from the school

✓ 5. Letter from your internship or residency program form completed & signed by Dr Johnston

✓ 6. Letter from Alaska institution accepting responsibility for training form complete & signed by Dr Johnston.

_____ 7. Residency application fee of $30.00

_____ 8. Residency permit fee of $20.00

Additional Comments: Permit expires 7/7/99

The next written correspondence you will receive will be sent once your file becomes complete.

Please remember it is your responsibility to keep this office advised of your current mailing address at all times.

If you have any questions, please do not hesitate to contact this office.

Sincerely,

Nancy Ferguson
Licensing Examiner
State Medical Board

cc: Roni Macy
Residency Coordinator
FAX

08-676 (Rev. 3/99)

0049

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
333 WILLOUGHBY AVENUE, NINTH FLOOR
P.O. BOX 110806, JUNEAU, ALASKA 99811-0806
(907) 465-2541

FOR OFFICE USE ONLY
DATE
RECEIVED
JUN 01 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

TO THE APPLICANT

Complete the identifying information and submit to:

Drug Enforcement Administration
220 West Mercer, Suite 104
Seattle, Washington 98119

Attention: Diversion Unit

Date: April 5, 1999

To Whom It May Concern:

I am applying for a license to practice medicine in the State of Alaska. Please indicate on the lower portion of this letter if there is any derogatory information on file against me and send this information directly to the Alaska State Medical Board. Thank you for your assistance.

NAME: Joey Michele Banks

DATE OF BIRTH: [redacted]

DEA REGISTRATION NUMBER: [redacted]

ADDRESS WHERE DEA NUMBER IS REGISTERED: Providence Alaska Medical Center
3200 Providence Drive
Anchorage, AK 99508

Joey Banks
Signature of Applicant

The files of this office contain no derogatory information relative to the above subject
D.E.A. 5/28/99

08-4105g (Rev. 4/97)

0050 NF/dgl

No. 1059

Effective: 06/30/1999

Expires: 12/30/2000

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

Division of Occupational Licensing

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

STATE MEDICAL BOARD

Certifies that

JOEY MICHELE BANKS

IS A PHYSICIAN

IN A RESIDENCY PROGRAM

RESIDENT AT THE ALASKA FAMILY PRACTICE RESIDENCY PROGRAM

Commissioner: Deborah B. Sedwick

Wallet Card

No. 1059

State Of Alaska

Department of Commerce and Economic Development

Division Of Occupational Licensing

This Certifies that

JOEY MICHELE BANKS

IS A PHYSICIAN

IN A RESIDENCY PROGRAM

Effective	Expiration	Date of Birth
06/30/1999	12/30/2000	[redacted]

RESIDENT AT THE ALASKA FAMILY PRACTICE RESIDENCY PROGRAM

Signature ______________________

MED

JOEY MICHELE BANKS
3546 LATOUCHE ST
ANCHORAGE AK 99508

No. 1230
Effective: 09/28/1999
Expires: 03/28/2000

STATE OF ALASKA

DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT
Division of Occupational Licensing
P.O. Box 110806, Juneau, Alaska 99811-0806

STATE MEDICAL BOARD

Certifies that

JOEY MICHELE BANKS

IS A PHYSICIAN

WITH A TEMPORARY PERMIT TO PRACTICE MEDICINE

VALID FOR NO MORE THAN SIX MONTHS FROM 9/28/99

Commissioner: Deborah B. Sedwick

Wallet Card

No. 1230 State Of Alaska
Department of Community and Economic Development
Division Of Occupational Licensing
This Certifies that
JOEY MICHELE BANKS
IS A PHYSICIAN
WITH A TEMPORARY PERMIT TO PRACTICE MEDICINE

Effective	Expiration	Date of Birth
09/28/1999	03/28/2000	[redacted]

VALID FOR NO MORE THAN SIX MONTHS FROM 9/28/99

Signature ____________________

Your file is complete and will be reviewed at the next State Medical Board meeting tentatively scheduled for 10/21 & 22/99.

Per 12 AAC 02.900 you must notify our office in writing if you change your mailing address. You may fax your address change to (907)465-2974.

JOEY MICHELE BANKS
C/O AK FAMILY PRACTICE RESIDENCY
3546 LATOUCHE ST
ANCHORAGE AK 99508

MED

ALASKA
Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT

RECEIVED
MAY 26 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

VERIFICATION OF ACCEPTANCE BY ALASKA FACILITY, HOSPITAL, CLINIC

Instructions to Resident Applicant: Please complete Part I of this document and forward to the Alaska facility, hospital, or clinic where you intend to serve your residency rotation.

PART I RESIDENT-IN-TRAINING:

Joey Michele Banks MD Family Practice
Name of Resident Physician Degree Speciality

AMA-APPROVED RESIDENCY TRAINING PROGRAM:

ALASKA FAMILY PRACTICE RESIDENCY Anchorage, Alaska
Name of Program Location

Instructions to Alaska Facility: Please complete Parts II and III and return this document to the Alaska State Medical Board at the address above.

PART II RESIDENCY ROTATION TO BE SERVED AT:

ALASKA FAMILY PRACTICE RESIDENCY
Name of Alaskan Facility, Hospital, Clinic

3546 LaTouche Street Anchorage, AK 99508
Address

June 28, 1999 through June 30, 2002
Dates of Rotation

PART III ALASKA-LICENSED PHYSICIANS TO WORK WITH RESIDENT:

Physician Name	AK Lic. No.	Physician Name	AK Lic. No.
David A. Driggers, MD	3846 12/31/2000	Paul W. Davis, MD	2541 12/31/2000
Dwight S. Smith, MD	3736 12/31/2000	Paul D. Forman, MD	3728 12/31/2000

I CERTIFY that the Resident Physician named above has been accepted by this institution to serve as a resident. This institution accepts responsibility for this resident physician's training while he/she is located at this institution.

Veronica (Roni) Macy
Printed Name of Representative

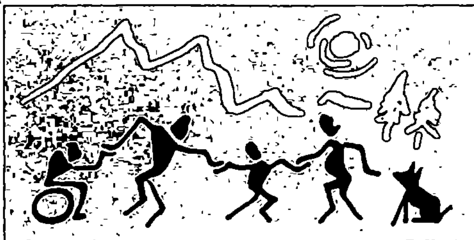
Veronica (Roni) Macy
Signature

Residency Coordinator
Title of Representative

April 5, 1999
Date

08-4022 b (Rev 10/97) 6/23/99 ok per Leslie

0053



ALASKA FAMILY PRACTICE RESIDENCY
3546 LaTouche Street Anchorage, Alaska 99508
907-561-4500 phone
907-561-4806 fax

RECEIVED
MAY 2 8 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

May 13, 1999

Alaska Department of Commerce & Economic Development
Division of Occupational Licensing
PO Box 110806
Juneau, AK 99811-0806

Re: Joey Michele. Banks, MD
DOB: [redacted]
SSN: [redacted]
Indiana University Medical School, May 1998

To Whom It May Concern:

Joey Banks has been accepted in good standing into the Alaska Family Practice Residency owned by Providence Alaska Medical Center. The above named individual will start their training on June 21, 1999. This resident will be under the direct supervision and authority of the Alaska Family Practice Residency faculty.

Sincerely,

Roni Macy

Veronica (Roni) Macy
Program Coordinator

MED
687476
(611)

ALASKA FAMILY PRACTICE RESIDENCY

3546 LaTouche Street Anchorage, Alaska 99508
907-561-4500 phone
907-561-4806 fax

'99 MAY 28 PM 1 30

50.00 To 4,740.00 ✓ Ppm

May 27, 1999

Ms. Nancy Ferguson
Division of Occupational Licensing
State Medical Board
333 Willoughby Avenue – Nine Floor
Juneau, AK 99811-0806

Re: Resident Permit Applications for Incoming Residents
Resident Permit Applications – Renewal for Current First Year Class
Resident Application for License – Current First Year Class

22

Dear Nancy:

Hello from the Residency. There is a great deal of activity going on here and it is going to be an exciting year with the arrival of our third class. The Residency will now have its 24 residents as planned. Can you believe this?

I have enclosed three batches of applications as per the above subject line. We want to ensure that the current resident permits do not expire while we await USMLE scores to reach you. These residents will not graduate from internship year until June 27, 1999. As soon as the internship certificate is signed I will transmit CTC's of it to you.

Providence prepared one check for our application fees and unfortunately one other department's fees for Nurse Aide Board of Registry. The check stub and attached printout of detail will explain amounts. Please contact me if you have any questions about the check. Bummer.

Nancy, we appreciate your hard work and eagle eye for detail. Please let me know if you need anything from us—or the residents. I can locate the resident and have them contact you ASAP. Also, it would be helpful again to have a photocopy of the licenses for our files before you mail them to the residents.

Thank you,

Roni Macy

Veronica (Roni) Macy
Residency Coordinator

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FOR OFFICE USE ONLY
DATE

RECEIVED
MAY 28 1999
DIVISION OF
OCCUPATIONAL LICENSING

NOTICE

The Alaska State Medical Board requires letters of standing from all hospitals where you hold or have held privileges in the past five years.

1. You must request each hospital to submit a letter regarding the status of your privileges to the address below:

State of Alaska
Department of Commerce and Economic Development
Division of Occupational Licensing
State Medical Board
P.O. Box 110806
Juneau, Alaska 99811-0806

2. You must complete the bottom portion of this form and return with your initial application.

If you have never held hospital privileges, please note on this form, sign and submit this form as part of your application.

HOSPITAL	COMPLETE MAILING ADDRESS
NONE	

I certify that listed above are **all** hospitals where I hold or have held privileges in the past five years. I understand it is my responsibility to request these hospitals to submit a letter to the Alaska State Medical Board to complete my application for licensure.

I certify under penalty of unsworn falsification that the above information furnished is true and correct.

WARNING: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application has committed a Class A misdemeanor.

[signature]
Signature

April 5, 1999
Date

0056 NF/dgl

08-4105e (Rev. 4/97)

MED
687476
(611)

ALASKA FAMILY PRACTICE RESIDENCY

3546 LaTouche Street Anchorage, Alaska 99508
907-561-4500 phone
907-561-4806 fax

'99 MAY 28 PM 1 30

50.00 2o 4,740.00 ✓ Ppm

May 27, 1999

Ms. Nancy Ferguson
Division of Occupational Licensing
State Medical Board
333 Willoughby Avenue – Nine Floor
Juneau, AK 99811-0806

Re: Resident Permit Applications for Incoming Residents
Resident Permit Applications – Renewal for Current First Year Class
Resident Application for License – Current First Year Class

22

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Providence prepared one check for our application fees and unfortunately one other department's fees for Nurse Aide Board of Registry. The check stub and attached printout of detail will explain amounts. Please contact me if you have any questions about the check. Bummer.

Nancy, we appreciate your hard work and eagle eye for detail. Please let me know if you need anything from us—or the residents. I can locate the resident and have them contact you ASAP. Also, it would be helpful again to have a photocopy of the licenses for our files before you mail them to the residents.

Thank you,

Roni Macy

Veronica (Roni) Macy
Residency Coordinator

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0057

INDIANA UNIVERSITY

School of Medicine

To all to whom these Presents may come, Greeting:

By vote of the Faculty and with the consent of the Board of Trustees, Indiana University hereby confers upon

Joey Banks

who has complied with all the requirements of the University and has successfully completed the studies prescribed for graduation in the School of Medicine the degree of

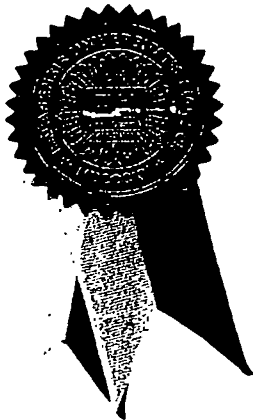
Doctor of Medicine,

with all the rights and privileges thereunto appertaining.

In Testimony Whereof, *this Diploma is issued, sealed with the Seal of the University, signed by the President of the University, Vice President, and by the Dean of the School of Medicine, and attested by the Secretary of the Trustees.*

Done at Indiana University - Purdue University at Indianapolis, Indiana,

this tenth day of May 1998.



Dean of the School of Medicine

President

Secretary of the Trustees

Vice President

ALASKA

Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT

RECEIVED
MAY 28 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

BIOGRAPHICAL DATA SHEET

Joey Michele Banks
NAME

3546 LaTouche Street
ADDRESS

Anchorage, AK 99508
CITY STATE ZIP CODE

(907) 562-9229
Work Phone

(907) 562-9229
Home Phone

907 337-5175

DATE OF BIRTH

USA Birth
CITIZENSHIP Birth/Naturalization?

PLACE OF BIRTH

FOR STATE MEDICAL BOARD USE ONLY:
Interview With: _____
Date: _____ *Time:* _____
Confirmed With: _____

Name/Location of Alaska Facility Where Serving Rotation

Dates of Rotation

Indiana University
Medical School

MD 1998
Degree Year Graduated

Alaska Family Practice Residency
Internship Program

Family Practice Program 2000
Type Year

Alaska Family Practice Residency
Residency Program

Family Practice Program 2002
Type Year

Family Practice
Specialty

Certifications

NOTE: Notary Public Seal must overlie a portion of the photograph.

Joey Banks
Signature of Applicant

4/5/99
Date

SUBSCRIBED AND SWORN to before me, a Notary Public, in and for the State of Alaska, this 5th day of April 1999.

Veronica (Roni) Macy
Notary Public

My commission expires: March 7, 2001.

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
333 WILLOUGHBY AVENUE, NINTH FLOOR
P.O. BOX 110806, JUNEAU, ALASKA 99811-0806
(907) 465-2541

FOR OFFICE USE ONLY
DATE
RECEIVED
MAY 28 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

ALASKA STATE MEDICAL BOARD
BIOGRAPHICAL DATA SHEET

Name in Full: Joey Michele Banks Social Security Number: [redacted]

Mailing Address: % Alaska Family Practice Residency 3546 LaTouche Street, Anchorage, AK 99508

Daytime Telephone Number: (907) 562-9229

Place of Birth: [redacted] Date of Birth: [redacted]

Are you a U.S. citizen? ☒ Yes ☐ No If yes, by birth ☒ naturalization ☐

If not a U.S. citizen, you must show your 1-151 card to the board member at the time of the interview.

Medical School: Indiana University

Year Graduated: 1998

Internship Program and Location: Alaska Family Practice Residency 3546 LaTouche St. Anchorage, AK

Type: Family Practice Program

Residency Program and Location: Alaska Family Practice Residency 3546 LaTouche St. Anchorage, AK 99508

Type: Family Practice Program

What is your specialty? Family Practice

Board Certified? ☐ Yes ☒ No When: ______

Where do you intend to practice in Alaska? undetermined

Anticipated date you plan to be working in Alaska: undetermined

NOTE: Notary Public Seal must overlie a portion of the photograph.

Joey Banks
Signature of Applicant

SUBSCRIBED AND SWORN to before me, a Notary Public in and for the State of Alaska this 5th day of April, 1999.

Veronica (Roni) Macy
Notary Public
My Commission Expires: March 7, 2001

SCHEDULED APPOINTMENT:

Interview with: ______

Date/Day: ______ *Time:* ______

Confirmed with: ______

0060
NF/dgl

08-4105c (Rev. 4/97)

687476 **MED**

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
333 WILLOUGHBY AVENUE, NINTH FLOOR
P.O. BOX 110806, JUNEAU, ALASKA 99811-0806
(907) 465-2541

FOR OFFICE USE ONLY
DATE
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RECEIVED
MAY 20 1998 (611)
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

STATE MEDICAL BOARD

$200.00 Nonrefundable Application Fee **$300.00 License Fee**

This application must be completed in full. If any section does not apply, please write N/A in the space provided. Type or print information.

I hereby apply for a license to practice as a
☒ Medical Doctor (M.D.) / ☐ Osteopath (D.O.) in the State of Alaska by: ☒ Examination ☐ Credentials

If applying by credentials, upon what state or provincial license or certificate do you base this application?
Certificate No.: N/A State: N/A Issue Date: N/A
Have you previously held a license, temporary permit, or locum tenens permit in the State of Alaska? ☒ Yes ☐ No
Anticipated date you plan to be working in Alaska: June 22, 1998

1. Name in Full: Joey Michele Banks Social Security No. [redacted]
2. Other Names Used, including Maiden Name: Joey Michele Journeycake
3. Legal Name Changes: Journeycake —> Banks
4. Practice Address: 3546 LaTouche Street Anchorage, AK 99508
5. Residence Address: 3546 LaTouche Street Anchorage, AK 99508

   How long at this residence? 1 year Home Phone: 562-9229 Work Phone: 562-9229
   Preferred mailing address is: ☒ Practice ☐ Home ☐ Other:
6. Place of Birth: [redacted] Date of Birth: [redacted]
7. Are you a U.S. Citizen? X☒ Yes ☐ No If yes, by birth ☒ / by naturalization ☐
   If no, what is your status? N/A
   List INS Alien Identification Number: N/A
   Date and Port of Entry into United States: N/A
   (Note: If applicable, you must show your 1-151 card at time of interview.)
8. MEDICAL EDUCATION - You must list ALL medical schools attended:

Name of School	Location	Month Year	
Indiana University	Bloomington, IN and Indianapolis, IN	From 8/94	To 5/98
		From	To
		From	To

Graduated from: Indiana University 1998
Exact Date on Diploma: 10th May 1998

0061
NF/dgl

08-4105 (Rev. 4/97)

9. List all states, territories, and foreign countries in which you hold or have held medical licenses. Include license number, current status of the license, and date license was first issued.

	STATES WHERE LICENSED	LICENSE NUMBER	CURRENT STATUS	DATE ISSUED
a.	Alaska	Resident permit 648	Residency Program	7/8/98
b.				
c.				
d.				
e.				

(Continue list on separate sheet, if necessary.)

DIVISION OF OCCUPATIONAL LICENSING
MAY 28 1999
JUNEAU

10. What is your specialty? Family Practice
Board Certified? ☐ Yes ☒ No Board Eligible? ☐ Yes ☒ No
Date of Certification: Pending completion of Residency, June 2001

11. Where did you complete your internship? (Hospital name, complete address, including zip code and period of service) Providence Alaska Medical Center 3200 Providence Drive Anchorage, AK 99508
Alaska Family Practice Residency 3546 LaTouche Street Anchorage, AK 99508

12. Where did you complete your residency? (Hospital name, complete address, including zip code and period of service) In the process at Alaska Family Practice Residency
3546 LaTouche Street Anchorage, AK 99508

13. Have you ever had hospital privileges in any hospital? ☐ Yes ☒ No
If so, give name and address of hospital and period of service.

14. To what country, district, or state medical societies have you belonged?
Name: Alaska State Medical Association Address: 4107 Laurel Street Anchorage, AK 99508
Name: Address:
Name: Address:

15. Have you ever taken the FLEX Examination? ☐ Yes ☐ No
Have you ever taken the National Boards? ☐ Yes ☐ No
Have you ever taken USMLE? ☒ Yes ☐ No

16. Have you ever served in the Armed Forces? ☐ Yes ☒ No
If so, date of commission: and date of discharge:
Branch of Service:
Locations where you served:

Please answer the following questions by indicating "YES" or "NO." A "YES" response does not automatically result in a denial of license application. Provide all pertinent details for any "YES" response; this will help expedite further processing of your application. (AS 08.64.200; AS 08.64.240; AS 08.64.326)

DISCIPLINARY HISTORY:

		YES	NO
17.	Have you ever been denied a certificate by, or the privilege of taking an examination before any state medical board?	☐	☒
18.	Have you ever been the subject of an inquiry or under investigation by any state board or other licensing agency concerning a violation or alleged violation of any state regulation, statute, or law, for any violation or alleged violation of the medical practice act, or unprofessional or unethical conduct, or for sexual misconduct?	☐	☒
19.	Have you ever had a license to practice medicine disciplined, restricted, limited, suspended, revoked, or otherwise disciplined by any licensing agency, credentialing authority, medical board, or military authority?	☐	☒
20.	Have you ever voluntarily agreed to limitations or restrictions being placed on your license or voluntarily surrendered your license to practice medicine in any licensing jurisdiction?	☐	☒

(CONTINUED)

		YES	NO
21.	Have you ever been charged or convicted of a violation of a law, statute, or regulation of the United States, Canada, or Mexico, excluding minor traffic violations.	☐	☒
22.	Have you ever been charged with or convicted of a violation of any United States, Canadian, or Mexican narcotics or controlled substances laws?	☐	☒
23.	During your medical school education, were you ever placed on probation, suspended, restricted, or otherwise disciplined for any reason?	☐	☒
24.	Have you ever been under investigation or disciplined by military authorities or any hospital, medical school, or internship or residency program relating to the practice of medicine (including being placed on probation, receiving a letter of reprimand, censured, etc.)?	☐	☒
25.	Have you ever had hospital privileges revoked, conditioned, restricted, or had any disciplinary action regarding your privileges (with the exception of temporary suspension pending completion of medical records)?	☐	☒
26.	Have you ever applied for and been denied a DEA Registration Number?	☐	☒
27.	Have you ever surrendered your DEA Registration Number?	☐	☒
28.	Have you ever been convicted of a violation of any federal or state narcotic law?	☐	☒
29.	Have you ever had any malpractice settlements or judgements paid on your behalf?	☐	☒

RECEIVED
MAY 28 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

PERSONAL HISTORY

		YES	NO
30.	Within the five years immediately preceding your completion and submission of this application for licensure, have you been diagnosed with, or treated for, or had problems related to emotional or mental illness, drug addiction, or alcoholism?	☐	☒

If you answer "YES" to the above question, please provide detailed information including the names, addresses, and telephone numbers of any counselors, therapists, or other providers from whom you sought treatment.

All information supplied with this application will be considered public unless required to be kept confidential by state or federal laws.

MEDICAL WORK HISTORY

31. Please include all medical work history since graduation from medical school. (You may enclose a C.V. as long as all information required is included.)

DATES	NAME AND ADDRESS	PRIVILEGES/SCOPE OF PRACTICE
June 22, 1998 – present	Providence Hospital 3200 Providence Drive Anchorage AK 99519	Resident Permit

(Use additional sheets if necessary)

RECEIVED
MAY 28 1999
DIVISION OF
OCCUPATIONAL LICENSING

MEDICAL MALPRACTICE HISTORY

32. You must submit a list of negotiated settlements, judgements, or awards in claims or civil actions alleging medical malpractice against you, including an explanation of the basis for each claim or action. **(If none, please write "None.")** - AS 08.64.200(a)(3).

Date of Occurrence	Amount Paid	Nature of the Alleged Malpractice
		NONE

(Use additional sheets, if necessary)

33. I HEREBY CERTIFY that the information contained in this application is true and correct to the best of my knowledge. I further certify that all credentials supplied by me are true and correct and that the photograph which appears below is a true likeness of myself taken within the past 60 days. I understand that any false information or falsification of credentials may result in failure to obtain a license to practice medicine and surgery in the State of Alaska.

Joy Banks
Signature of Applicant

SUBSCRIBED AND SWORN to before me, a Notary Public, in and for the State of Alaska
this 5th day of April, 19 99.

Veronica (Roni) Macy
Notary Public

My Commission Expires: March 7, 2001

NOTARY SEAL

NOTE: NOTARY PUBLIC SEAL MUST OVERLIE A PORTION OF THE PHOTOGRAPH.

ALASKA

Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT

678476

For Department Use Only
RECEIVED
MAY 28 1999
DIVISION OF
OCCUPATIONAL LICENSING

50.00 to 4,740.00

NAME: Joey Michele Banks

ADDRESS: 3546 LaTouche Street
Anchorage, AK 99508

PHONE NO. Wk 907-562-9229 Hm (907) 562-9229

DATE OF BIRTH [redacted] SSN [redacted]

CITIZENSHIP: USA (Birth)/Naturalization? (Circle One)

Submit Fee:
Resident Permit $50

WHERE LICENSED: Alaska
(States, Territories, Foreign Countries. Include Current Status)

Please answer the following questions by indicating "YES" or "NO". A "YES" response does not automatically result in a denial of license application. Provide all pertinent details for any "YES" response; this will help expedite further processing of your application.

DISCIPLINARY HISTORY:

1. Have you ever been the subject of an inquiry or under investigation by any state board or other licensing agency concerning a violation or alleged violation of any state regulation, statute, or law, for any violation or alleged violation of the medical practice act, for unprofessional or unethical conduct, or for sexual misconduct? NO ☒ YES ☐
2. Have you ever had a license to practice medicine disciplined, restricted, limited, suspended, revoked, or otherwise disciplined by any licensing agency, credentialing authority, medical board, or military authority? NO ☒ YES ☐
3. Have you ever voluntarily agreed to limitations or restrictions being placed on your license or voluntarily surrendered your license to practice medicine in any licensing jurisdiction? NO ☒ YES ☐
4. Have you ever been charged or convicted of a violation of a law, statute, or regulation of the United States, Canada, or Mexico, excluding minor traffic violations? NO ☒ YES ☐
5. Have you ever been charged with or convicted of a violation of any United States, Canadian, or Mexican narcotics or controlled substances laws? NO ☒ YES ☐
6. Have you ever been under investigation or disciplined by military authorities or any hospital, medical school, or internship or residency program relating to the practice of medicine? NO ☒ YES ☐

PERSONAL HISTORY:

Within the five years immediately preceding your completion and submission of this application for licensure, have you suffered from or been treated for emotional or mental illness or substance abuse (including but not limited to alcohol, narcotics, or any other substance)? NO ☒ YES ☐

If you answer "YES" to the above question, please provide detailed information including the names, addresses, and telephone numbers of any counselors, therapists, or other providers from whom you sought treatment.

I CERTIFY that the information above is true and correct. I understand that any false information may result in the revocation of my resident-in-training permit.

Joey Banks
Signature of Applicant

Date 4/05/99

WARNING:
Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application is subject to imprisonment for not more than one year, a fine of not more than $5,000, or both.

08-4022 (10/97)

ALASKA
Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT

RECEIVED
MAY 28 1999
DIVISION OF
OCCUPATIONAL LICENSING

AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, Joey Michele Banks, residing at AFPR, 3546 LaTouche Street Anchorage, AK 99508, hereby authorize the Alaska Division of Occupational Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Occupational Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the Division to discuss my records with persons or organizations which are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof , that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Joey Banks
Signature of Applicant

4/5/99
Date

(907) 562-9229
Home Phone Number

(907) 562-9229
Work Phone Number

Date of Birth

Social Security Number

08-4022 d (Rev 10/97)

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
STATE MEDICAL BOARD
333 WILLOUGHBY AVENUE, NINTH FLOOR
P.O. BOX 110806, JUNEAU, ALASKA 99811-0806
(907) 465-2541

FOR OFFICE USE ONLY
DATE
RECEIVED
MAY 23 1999
DIVISION OF
OCCUPATIONAL LICENSING

AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, Joey Michele Banks, residing at

AFPR, 3546 LaTouche Street Anchorage, AK 99508, hereby authorize the Alaska Division of Occupational Licensing and its investigators to examine my medical and dental records, employment and educational records, and any records pertaining to litigation, judgements, suits and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Occupational Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the Division to discuss my records with persons or organizations which are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records of those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, drug or alcohol evaluation, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a certified true copy, you provide copies of those records to the Division and/or its investigators and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization is given expressly in connection with my application for initial issuance or renewal or reactivation for Alaska license to practice medicine, a locum tenens, or resident permit to practice medicine, or a physician assistant license, or mobile intensive care paramedic license. This authorization expires one year from the date of my signature.

Joey Banks
Signature of Applicant

April 5, 1999
Date

(907) 562-9229
Home Telephone Number

(907) 562-9229
Work Telephone Number

Date of Birth

Social Security Number

08-4105b (Rev. 4/97)

0067 NF/dgl

FedEx
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TRK# 8070 8216 3633 FORM 0210

PRIORITY OVERNIGHT TUE

Deliver By:
1JUN99
AT

SEA

99811 -AK-US 85 JNUA

THIS STRIP TO BE

FedEx. USA Airbill

1 From

Date 5/27/99

Sender's Name

Phone (907)

Company PROVIDENCE HOSPITAL

Address 3546 LA TOUCHE

Dept./Floor/Suite/Room

City ANCHORAGE State AK ZIP

2 Your Internal Billing Reference Information 8241

3 To

Recipient's Name

Phone (907)

Company Div of Drug Licensing

Address 333 Willoughby Avenue

(To "HOLD" at FedEx location, print FedEx address here)

Check here if residence (Extra charge applies for FedEx Express Saver)

Dept./Floor/Suite/Room

City Juneau State AK ZIP

For HOLD at FedEx Location check here

- Hold Weekday (Not available with FedEx First Overnight)
- Hold Saturday (Not available at all locations) (Available for FedEx Priority Overnight and FedEx 2Day only)

WEEKEND Delivery check here (Extra Charge. Not available at all locations)

- Saturday Delivery (Available for FedEx Priority Overnight and FedEx 2Day only)
- NEW Sunday Delivery (Available for FedEx Priority Overnight only)

8070 8216 3633

Recipie

4a Express Package Service *Packages under 150 lbs.*

- FedEx Priority Overnight (Next business morning)
- FedEx Standard Overnight (Next business afternoon)
- FedEx First Overnight (Earliest next business morning delivery to select locations)
- FedEx 2Day (Second business day)
- FedEx Express Saver (Third business day)

FedEx Letter Rate not available. Minimum charge: One pound rate.

4b Express Freight Service *Packages over 150 lbs.*

- FedEx Overnight Freight (Next business day)
- FedEx 2Day Freight (Second business day)

(Call for delivery schedule. See back for detailed descriptions of f

5 Packaging

- FedEx Letter
- FedEx Pak
- FedEx Box

Declared value limit $500

6 Special Handling

Does this shipment contain dangerous goods?* No Yes

Dry Ice
Dry Ice, 9, UN 1845 ____ x ____ kg.

*Dangerous Goods can

7 Payment

Bill to: Sender (Account No. in Section 1 will be billed) Recipient Third Party

(Enter FedEx Account No. or Credit Card No. below)

Total Packages 1 Total Weight 5 Total Declared Value* $ .00

*When declaring a value higher than $100 per shipment, you pay an additional charge. See SERVICE CONDITIONS, DECLARED VALUE, AND LIMIT OF LIABILITY section for further information.

8 Release Signature

Your signature authorizes Federal Express to deliver this shipment without obtaining a signature and agrees to indemnify and hold harmless Federal Express from any resulting claims.

Questions?
Call 1·800·Go·FedEx® (800)463-3339

321

0059261128 3

No. 648

Effective: 07/08/1998
Expires: 07/07/1999

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT
Division of Occupational Licensing
P.O. Box 110806, Juneau, Alaska 99811-0806

State Medical Board

Certifies That

Is A Physician
in a Residency Program

RESIDENT AT ALASKA FAMILY PRACTICE RESIDENCY PROGRAM

Commissioner: Deborah B. Sedwick

Wallet Card - Cut along dotted lines

No. 648 STATE OF ALASKA
DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT
Division of Occupational Licensing
This certifies that

Is a Physician in a Residency Program

Effective	Expiration	Date Of Birth
07/08/1998	07/07/1999	00/00/0000

Height	Weight	Sex	Eyes	Hair
00	000			

RESIDENT AT ALASKA FAMILY PRACTICE RESIDENCY PROGRAM

Signature:______________________________

MED

730 BANCROFT
INDIANAPOLIS IN 46201

Author: Leslie Abel at DCED_FRONT
Date: 7/8/98 9:47 AM
Priority: Normal
Receipt Requested
TO: Nancy Ferguson at dced_jun1
Subject: Re: 3 residents

------------------------------------ Message Contents ------------------------------------

Banks

Please send the permits to

Alaska Family Practice Residency Program
Attn: Ronnie Macy
3546 LaTouche
Anchorge AK 99508

I have asked Ronnie to send you change of address notices for these residents as we have their outside addresses only and I'm sure they don't want their permits sent outside!

Thanks

______________________________ Reply Separator ______________________________

Subject: 3 residents
Author: Nancy Ferguson at dced_jun1
Date: 7/7/98 4:34 PM

The bio on the RP forms do not list SSN. Please advise for:
Banks Thanks

WORKSTATION 138 - USER LGH - Leslie Abel Anch Occ Lic

3:05:33 pm Friday July 10, 1998

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************************************************************************************
****         1         2         3         4         5         6         7         8 ****
**** 1234567890123456789012345678901234567890123456789012345678901234567890 ****
************************************************************************************
*  *                                                                           *  *
* 1*  Display Master Plus License                                              * 1*
* 2*                                                                           * 2*
* 3*  Board/Type/Lic: MED R 648    RESIDENT TEMPORARY PERMIT  BL # 000000      * 3*
* 4*  Rec # 000000 Rec Date         SIC 0000 Action (N/R)   BL EFFECT DT       * 4*
* 5*  License Status: ACTIVE LICENSE          SSN:[redacted]    Tobacco (Y/N)  * 5*
* 6*  Name..........: BANKS                               JOEY                 * 6*
* 7*  License name  : JOEY BANKS                                               * 7*
* 8*  Address.......: 730 BANCROFT                                             * 8*
* 9*  ..............:                                                          * 9*
*10*  City/ST/Zip...: INDIANAPOLIS    IN   46201 - 0000   Bus Phone: (   )   - *10*
* 1*  D B A.........:                                                          * 1*
* 2*  Curr Issue Dt.: 07/08/98 Expiration Date: 07/07/99 First Issue Dt: 07/08/98 * 2*
* 3*  Code Data.....: 070898  Initials: NF Bus Type (Domest,Foreign,Sole,Corp)  * 3*
* 4*  Audited/Date..:              Exam:   Cred:     NSF:   Do Not Issue:      * 4*
* 5*  License Print: RESIDENT AT ALASKA FAMILY PRACTICE RESIDENCY PROGRAM      * 5*
* 6*                                                                           * 6*
* 7*                                                                           * 7*
* 8*                                                                           * 8*
* 9*  Comments.....: MEDICAL DOCTOR                                            * 9*
*20*                                                                           *20*
* 1*                                                                           * 1*
* 2*  Height.......:    WT:     Sex:   Hair:          Eyes:          Birth:    * 2*
* 3*  ________________________________________________________________________ * 3*
* 4*   9) Modify   10) Comments   11) Lic Address  12) Lic Printed      16) Return * 4*
*  *                                                                           *  *
************************************************************************************
****         1         2         3         4         5         6         7         8 ****
**** 1234567890123456789012345678901234567890123456789012345678901234567890 ****
************************************************************************************
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STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

TONY KNOWLES, GOVERNOR

3601 C STREET, SUITE 722
ANCHORAGE, ALASKA 99503-5934
PHONE: (907) 269-8160
FAX: (907) 269-8156
TDD: (907) 465-5437

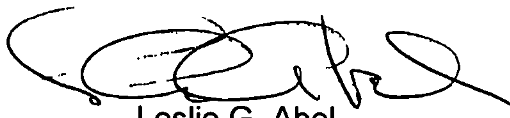
June 22, 1998

Joey Banks, MD
730 N. Bancroft
Indianapolis IN 46201

You application for a resident permit to practice medicine in Alaska was received by this office. Effective August 7, 1996, Alaska Statute 08.64.279 was amended and now provides for the personal interview requirement to be optional.

Your application file is complete and has been approved for the issuance of a resident permit. The permit will be issued from and mailed by the Juneau office to your application address. Please notify our Juneau office immediately of any address change.

Thank you for your cooperation, Dr. Banks, and we wish you success in your residency program in Alaska.



Leslie G. Abel
Executive Administrator
Alaska State Medical Board

xc: Veronica Macy - AFPRP
3546 LaTouche Street
Anchorage AK 99508

appstatus wpd

ALASKA

Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT

NAME: Joey Banks

ADDRESS: 730 N Bancroft
Indianapolis IN 46201

PHONE NO. Wk 907-561-4500 Hm 317-357-6958

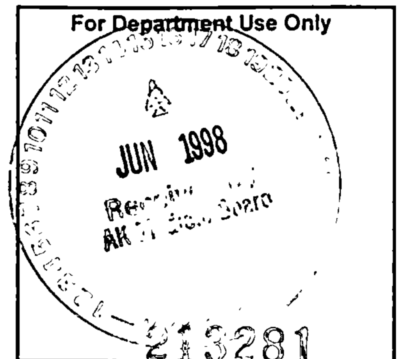
DATE OF BIRTH [redacted] SSN [redacted]

CITIZENSHIP: USA Birth/Naturalization? (Circle One)

WHERE LICENSED:

(States, Territories, Foreign Countries. Include Current Status)

For Department Use Only



Submit Fee: $50 — ck
Resident Permit $50

Please answer the following questions by indicating "YES" or "NO". A "YES" response does not automatically result in a denial of license application. Provide all pertinent details for any "YES" response; this will help expedite further processing of your application.

DISCIPLINARY HISTORY:

1. Have you ever been the subject of an inquiry or under investigation by any state board or other licensing agency concerning a violation or alleged violation of any state regulation, statute, or law, for any violation or alleged violation of the medical practice act, for unprofessional or unethical conduct, or for sexual misconduct? NO ☒ YES ☐
2. Have you ever had a license to practice medicine disciplined, restricted, limited, suspended, revoked, or otherwise disciplined by any licensing agency, credentialing authority, medical board, or military authority? NO ☒ YES ☐
3. Have you ever voluntarily agreed to limitations or restrictions being placed on your license or voluntarily surrendered your license to practice medicine in any licensing jurisdiction? NO ☒ YES ☐
4. Have you ever been charged or convicted of a violation of a law, statute, or regulation of the United States, Canada, or Mexico, excluding minor traffic violations? NO ☒ YES ☐
5. Have you ever been charged with or convicted of a violation of any United States, Canadian, or Mexican narcotics or controlled substances laws? NO ☒ YES ☐
6. Have you ever been under investigation or disciplined by military authorities or any hospital, medical school, or internship or residency program relating to the practice of medicine? NO ☒ YES ☐

PERSONAL HISTORY:

Within the five years immediately preceding your completion and submission of this application for licensure, have you suffered from or been treated for emotional or mental illness or substance abuse (including but not limited to alcohol, narcotics, or any other substance)? NO ☒ YES ☐

If you answer "YES" to the above question, please provide detailed information including the names, addresses, and telephone numbers of any counselors, therapists, or other providers from whom you sought treatment.

I CERTIFY that the information above is true and correct. I understand that any false information may result in the revocation of my resident-in-training permit.

Joey Banks
Signature of Applicant

Date 4/15/98

WARNING:
Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application is subject to imprisonment for not more than one year, a fine of not more than $5,000, or both.

08-4022 (10/97)

NOTES

RECEIPT

DATE 6/16/98 NO. 3131

RECEIVED FROM Providence Health Dept.

ADDRESS

$ 50 —

FOR Resident App for Joey Banks

ACCOUNT			HOW PAID		
AMT. OF ACCOUNT			CASH		
AMT. PAID	50 —		CHECK	167182	
BALANCE DUE			MONEY ORDER		

213281

BY LAS

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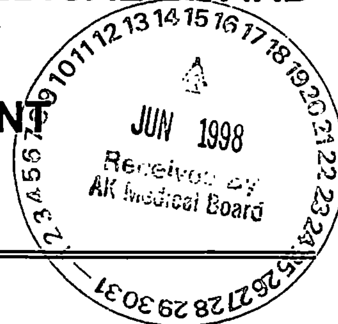
ALASKA
Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT



AUTHORIZATION FOR RELEASE OF RECORDS

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I, Joey Banks, residing at 730 N Bancroft Indianapolis IN 46201, hereby authorize the Alaska Division of Occupational Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Occupational Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

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This authorization expires one (1) year from the date of my signature below.

Joey Banks	4/3/98
Signature of Applicant	Date
317-357-6958	317-357-6958
Home Phone Number	Work Phone Number
Date of Birth	Social Security Number

08-4022 d (Rev 10/97)

ALASKA

Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT

BIOGRAPHICAL DATA SHEET

NAME: Joey Banks

DATE OF BIRTH: [redacted]

ADDRESS: 730 N Bancroft

CITIZENSHIP: USA   Birth/Naturalization?

CITY: Indianapolis   STATE: IN   ZIP CODE: 46201

PLACE OF BIRTH: Lawton Oklahoma

Work Phone: 317-357-6958

Home Phone: 317-357-6958

FOR STATE MEDICAL BOARD USE ONLY:
Interview With: ______
Date: ______ *Time:* ______
Confirmed With: ______

Name/Location of Alaska Facility Where Serving Rotation: Providence Alaska Med Center

Dates of Rotation: June 22, 1998 - June 30, 2001

Medical School: Indiana University Med School

Degree: MD   Year Graduated: 1998

Internship Program: Alaska Family Practice Residency

Type: Family Practice   Year: 98-99

Residency Program: Alaska Family Practice Residency

Type: Family Practice   Year: 99-2001

Spec[ialty]: Family Practice

Certifications: ______

Signature of Applicant: Joey Banks

Date: 4/5/98

SUBSCRIBED AND SWORN to before me, a Notary Public, in and for the State of Indiana, this 5 day of April 1998.

[signature]
Notary Public Deborah E. Schultz
Residing in Johnson County
My commission expires: May 13, 1999.

NOTE: Notary Public Seal must overlie a portion of the photograph.

INDIANA UNIVERSITY

School of Medicine

To all to whom these Presents may come, Greeting:

By vote of the Faculty and with the consent of the Board of Trustees, Indiana University hereby confers upon

Joey Banks

who has complied with all the requirements of the University and has successfully completed the studies prescribed for graduation in the School of Medicine the degree of

Doctor of Medicine,

with all the rights and privileges thereunto appertaining.

In Testimony Whereof, this Diploma is issued, sealed with the Seal of the University, signed by the President of the University, Vice President, and by the Dean of the School of Medicine, and attested by the Secretary of the Trustees.

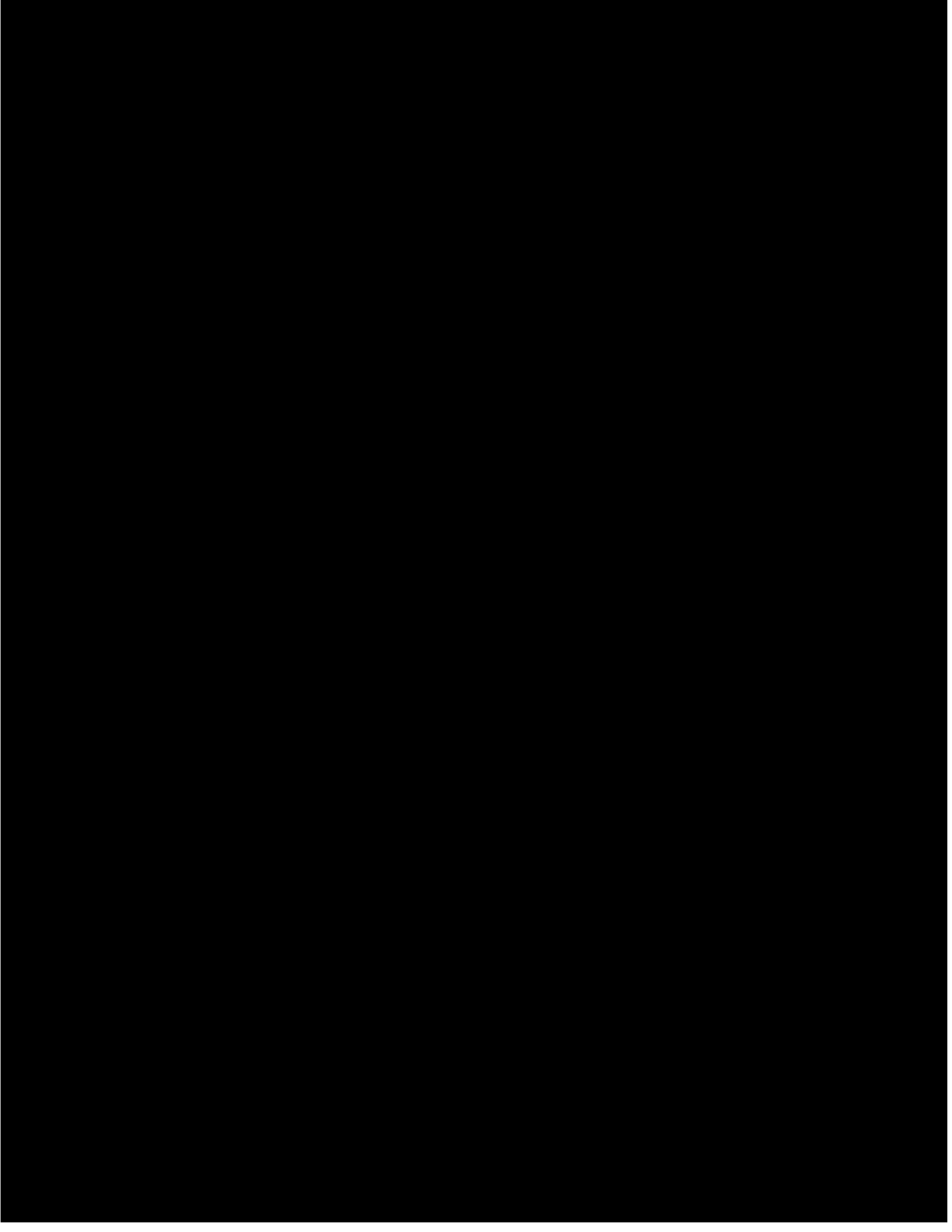
Done at Indiana University - Purdue University at Indianapolis, Indiana this tenth day of May 1998.

Dean of the School of Medicine

Preside

Secretary of the Trustees

Vice Preside



Indiana University School of Medicine

This Academic Record serves as an official record of student performance at the Indiana University School of Medicine.

The Indiana University School of Medicine is a statewide system of medical education. First and second year instruction is conducted at nine (9) different sites. Most required third year clinical rotations are taken at Indianapolis. The fourth year program allows for clinical and advanced science instruction in School-approved programs at various sites.

The Indiana University School of Medicine evaluation program is based on Honors, High Pass, Pass, Incomplete, and Fail. The percentage distribution of grades provided on this Academic Record is based on the grade distribution for each course at each site.

H – The Honors grade is to distinguish students who excel in meeting the course objectives.

HP – The High Pass grade is to identify students who are very good in meeting the course objectives.

P – Pass is for those students who satisfactorily meet the course objectives.

F – Fail is for those students who clearly did not meet the majority of course objectives.

I – Incomplete is to signify that extenuating circumstances have prevented the student from completing the course requirements. The incomplete must be removed before the student may proceed into the next year of study.

W – Withdraw is to signify that the student withdrew or was dismissed before completing course objectives.

EX – Exemption is to indicate that the student has been exempted from the course because of prior academic work.

DISCLOSURE OF INFORMATION CONTAINED IN THIS ACADEMIC RECORD MAY NOT BE MADE TO ANOTHER PARTY WITHOUT THE PRIOR WRITTEN CONSENT OF THE STUDENT WHOSE NAME APPEARS HEREIN. THIS INFORMATION MAY BE USED SOLELY BY THE INDIVIDUAL OR INSTITUTION TO WHICH IT WAS ORIGINALLY RELEASED FOR THE PURPOSE FOR WHICH THE DISCLOSURE WAS MADE.

TO TEST FOR AUTHENTICITY: The face of this document has a red background and the name of the institution appears in small print. Apply fresh liquid bleach to the sample background printed below. If authentic, the paper will turn brown.

INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF MEDICINE • INDIANA UNIVERSITY SCHOOL OF

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U.S. Patent 5,171,040 SCRIP-SAFE® Security Products, Inc., Cincinnati, OH

INDIANA UNIVERSITY

SCHOOL OF MEDICINE
OFFICE OF THE DEAN
STUDENT AND CURRICULAR AFFAIRS
John D. VanNuys Medical Science Building 162
635 Barnhill Drive
Indianapolis, Indiana 46202-5120

OFFICIAL TRANSCRIPT

Attn: FAM PRACT.
Roni Macy

0080

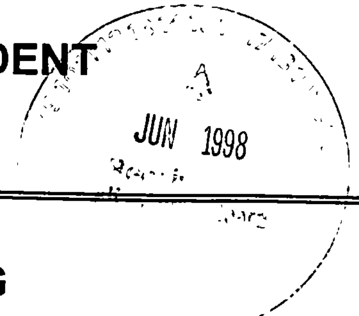
Office Student Affairs
I.U. S.O.M.

0081

ALASKA
Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT



VERIFICATION OF GOOD STANDING RESIDENCY TRAINING PROGRAM

RESIDENT-IN-TRAINING:

Joey Banks
Name of Resident Physician

RESIDENCY TRAINING PROGRAM:

Alaska Family Practice Residency
Name of Program

3546 LaTouche Street
Address of Program

Anchorage	Alaska	99508	907-561-4500
City	State	Zip Code	Phone No.

RESIDENCY ROTATION TO BE SERVED AT:

Providence Alaska Medical Center — Anchorage, AK
Name of Alaskan Facility, Hospital, Clinic — City

6/98 - 6/01
Dates of Rotation

I CERTIFY that the Resident Physician named above is a resident in good standing at the residency program shown above. This physician will be serving a portion of his/her clinical training at the Alaska institution as indicated. This program is approved by the Council on Medical Education of the American Medical Association or the Canadian Medical Association.

Harold Johnston
Signature, Director of the Residency Program

Harold L. Johnston, MD
Printed Name

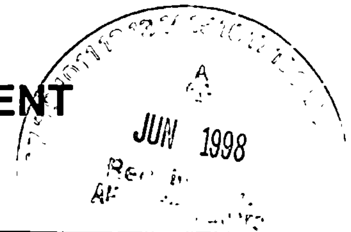
6/8/98
Date

08-4022 c (Rev 10/97)

ALASKA
Dept. Of Commerce & Economic Development
Division of Occupational Licensing
Post Office Box 110806
Juneau AK 99811-0806
(907) 465-2541
(907) 465-2974 - Fax
E-Mail: License@commerce.state.ak.us

STATE MEDICAL BOARD

RESIDENT



VERIFICATION OF ACCEPTANCE BY ALASKA FACILITY, HOSPITAL, CLINIC

Instructions to Resident Applicant: Please complete Part I of this document and forward to the Alaska facility, hospital, or clinic where you intend to serve your residency rotation.

PART I RESIDENT-IN-TRAINING:

Joey Banks — MD — Family Practice
Name of Resident Physician — Degree — Speciality

AMA-APPROVED RESIDENCY TRAINING PROGRAM:

Alaska Family Practice Residency — Anchorage, Alaska
Name of Program — Location

Instructions to Alaska Facility: Please complete Parts II and III and return this document to the Alaska State Medical Board at the address above.

PART II RESIDENCY ROTATION TO BE SERVED AT:

Alaska Family Practice Residency
Name of Alaskan Facility, Hospital, Clinic

3546 LaTouche Street, Anchorage AK 99508
Address

June 1998 thru June 2001
Dates of Rotation

PART III ALASKA-LICENSED PHYSICIANS TO WORK WITH RESIDENT:

Physician Name	AK Lic. No.	Physician Name	AK Lic. No.
Harold L. Johnston	2411	Paul W. Davis	2541
Debra D. Pohlman	2611	Dwight W. Smith	3736

I CERTIFY that the Resident Physician named above has been accepted by this institution to serve as a resident. This institution accepts responsibility for this resident physician's training while he/she is located at this institution.

Veronica (Roni) Macy
Printed Name of Representative

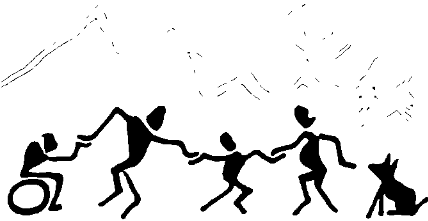
Veronica (Roni) Macy
Signature

Residency Coordinator
Title of Representative

6/8/98
Date

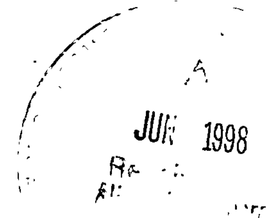
08-4022 b (Rev 10/97)

0083



ALASKA FAMILY PRACTICE RESIDENCY

3546 LaTouche Street Anchorage, Alaska 99508
907-561-4500 phone
907-561-4806 fax



June 15, 1998

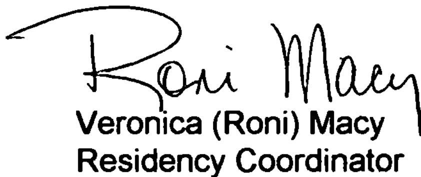
Leslie G. Abel, Executive Administrator
Division of Occupational Licensing
3601 C Street - Suite 722
Anchorage, AK 99503

Re: Joey M. Banks, MD
DOB:
SSN:
Indiana University Medical School, May 1998

Dear Leslie:

Joey Banks has been accepted in good standing into the Alaska Family Practice Residency and will start her training June 30, 1998. This resident will be under the direct supervision and authority of the Alaska Family Practice Residency faculty.

Sincerely,



Veronica (Roni) Macy
Residency Coordinator

RCMAINWINDOW

Exit
New
Delete
>
Query
<
Total
Clear
Payees
Batches

Batch Total | Total of Batches

Receipting

Batch #: 0L8A0240
Payer Name: PROVIDENCE HEALTH SYSTEM
Date Received: 06/16/1998
Entered By: NHARRIS

Reference #: 213281
(●) Check ( ) Money Order
( ) Cash ( ) Agency Journal
( ) Foreign Currency
Dollar Amount: $50.00
Comments:
Date Entered: 06/17/1998

Payee Name:	Occ Boards:	Dollar Amount:	N/R/C Code:	Colocation Code:	Ledger Code:	Account Code:
JOEY BANKS	MED	$50.00		08535001	08000242	58735

Check sheet completed: ____________ Date

Irregularities of comments regarding application: ☐ YES ☐ NO
If yes, please note:

(Use reverse if necessary)

Initials

RESIDENT APPLICATION CHECKLIST

Name: Banks, Joey, MD/DO

Date	
6/15/98	Completed Application Received
6/15	$50.00 Application/Permit Fees — Receipt No. 213281
6/15	Biographical Data Sheet
6/15	Authorization to Release Records
6/19	Medical School Diploma (Transcripts)
6/15	Residency Program Verification
6/15	Acceptance Letter from Alaska Facility

Alaska Family Practice Residency Program — Serving Residency Rotation at; Anch — City; 7/1/98 — Anticipated Dates

___ "Complete Application" Letter Sent

___ Interview required: ☐ Yes ☑ No

Interview with ____________ on ______

✓ Approved ___ Denied

Comments:

Signature: [signature] Date: 19 Jun 98

___ Resident Permit issued on ____________

Effective 07/01/98

Faxed copies to Nancy F. 7/2/98 [initials]

08-676 (Rev. 8/97)
NF/dgl

Check sheet completed: ____________
Date

Irregularities of comments regarding application: ☐ YES ☐ NO
If yes, please note:

(Use reverse if necessary)

Initials

RESIDENT APPLICATION CHECKLIST

Name: Banks, Joey, MD/DO

Need SSN

Date		
6/15/98	Completed Application Received	
6/15	$50.00 Application/Permit Fees	Receipt No. 213281
6/15	Biographical Data Sheet	
6/15	Authorization to Release Records	
6/19	Medical School Diploma (Transcripts)	
6/15	Residency Program Verification	
6/15	Acceptance Letter from Alaska Facility	

Alaska Family Practice Residency Program — Serving Residency Rotation at; Anch — City; 7/1/98 — Anticipated Dates

___ "Complete Application" Letter Sent

___ Interview required: ☐ Yes ☑ No

Interview with ____________ on ____________

✓ Approved ___ Denied

Comments:

Signature: [signature] Date: 19 Jun 98

RP 648 Resident Permit issued on 7/8/98 Effective 7/8/98

~~Effective 07/01/98~~

08-676 (Rev. 8/97)
NF/dgl

Check sheet completed: ____________
Date

Irregularities of comments regarding application: ☐ YES ☐ NO
If yes, please note:

(Use reverse if necessary)

Initials

RESIDENT APPLICATION CHECKLIST

Name: Banks Joey (MD)/DO
2nd year Resident

Date

✓ Completed Application Received

✓ $50.00 Application/Permit Fees Receipt No. 678476

✓ Biographical Data Sheet

✓ Authorization to Release Records

on file Medical School Diploma (Transcripts)

✓ Residency Program Verification

✓ Acceptance Letter from Alaska Facility

Alaska Residency Program — Serving Residency Rotation at; City: Anchorage; 6/28/99 - 6/30/2002 Anticipated Dates

— "Complete Application" Letter Sent

____ Interview required: ☐ Yes ☒ No

Interview with ____________ on ____

X Approved ____ Denied

Comments: ____________

Signature: [signature] Date: 29 Jun 99

RP 1059 Resident Permit Issued on 6/30/99 eff 6/30

08-676 (Rev. 8/97)
NF/dgl

Check sheet completed: ______________________
Date

Irregularities of comments regarding application: ☐ YES ☐ NO
If yes, please note:

____

____

____

____

(Use reverse if necessary)

______
Initials

RESIDENT APPLICATION CHECKLIST

Name: Banks Joey (MD)/DO

2nd year Resident

Date

✓ Completed Application Received

✓ $50.00 Application/Permit Fees Receipt No. 678476

✓ Biographical Data Sheet

✓ Authorization to Release Records

on file Medical School Diploma (Transcripts)

✓ Residency Program Verification

✓ Acceptance Letter from Alaska Facility

RECEIVED
JUN 30 1999
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

Alaska Residency Program — Serving Residency Rotation at
City: Anchorage
6/28/99 - 6/30/2002 — Anticipated Dates

– "Complete Application" Letter Sent

____ Interview required: ☐ Yes ☒ No

Interview with ______________________ on ________

✗ Approved ____ Denied

Comments: ______________________

Signature: [signature] Date: 29 Jun 99

____ Resident Permit issued on ______________________

08-676 (Rev. 8/97)
NF/dgl

Check sheet completed: ______ Date
Irregularities of comments regarding application: ☐ YES ☐ NO
If yes, please note:
(Use reverse if necessary)
______ Initials

RESIDENT APPLICATION CHECKLIST

Name: Banks Joey (MD)/DO

2nd year Resident

Date

✓ Completed Application Received

✓ $50.00 Application/Permit Fees Receipt No. 678476

✓ Biographical Data Sheet

✓ Authorization to Release Records

on file Medical School Diploma (Transcripts)

✓ Residency Program Verification

✓ Acceptance Letter from Alaska Facility

Alaska Residency Program (Serving Residency Rotation at) City Anchorage 6/28/99 - 6/30/2002 (Anticipated Dates)

– "Complete Application" Letter Sent

____ Interview required: ☐ Yes ☐ No
Interview with ______ on ______
____ Approved ____ Denied
Comments: ______
Signature: ______ Date: ______

____ Resident Permit issued on ______

08-676 (Rev. 8/97)
NF/dgl

Physician ✓ Osteopath ______
Foreign Medical Graduate ______
ECFMG No. ______

Check sheet completed ______ Date
Irregularities of comments regarding application. ☐ YES ☐ No
If yes, please note:
(Use reverse, if necessary)
______ Initials

MEDICAL CHECK LIST

Name Banks, Joey Michele

Application by Credentials based on: ______ Exam: USMLE

✓ Complete Application — Tentative Start Date Ak Residency Program
✓ Biographical Data Sheet; to Leslie —
✓ $200.00 Application Fee, Receipt # 697476
✓ $340.00 License Fee, Receipt # 687476
✓ Authorization to Release Records
✓ Verification of Exam Results
✓ Medical School Diploma Accredited ☑ Yes ☐ No, Unable to Locate
✓ Letter from Medical School Received 6/14/99
✓ All Internship/Residency Certificates Accredited ☑ Yes ☐ No, Unable to Locate
✓ Letter from Internship Program Received 6/22/99
none Verification of License(s) in ______
none Hospital Privileges Information Lust
✓ DEA Inquiry ______
✓ Federation Clearance see USMLE scores
✓ AMA Data Sheet ______
✓ NPDB Sent ✓ Received ✓

Interview required ☐ Yes ☒ No
Interview with ______ on ______

✓ Approved	______ Approved
______ Denied	______ Denied
Comments: ______	Comments: ______
[signature] 9/28/99	
Board Member Signature Date	Board Member Signature Date
License No. TP #1230 9/28/99	Issued: ______

08-4390 (Rev. 3/99)

Physician ✓ Osteopath ______
Foreign Medical Graduate ______
ECFMG No. ______

Check sheet completed ______ Date
Irregularities of comments regarding application. ☐ YES ☐ No
If yes, please note:
______
(Use reverse, if necessary)
______ Initials

MEDICAL CHECK LIST

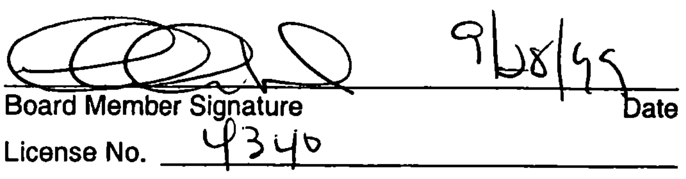
Name Banks, Joey Michele

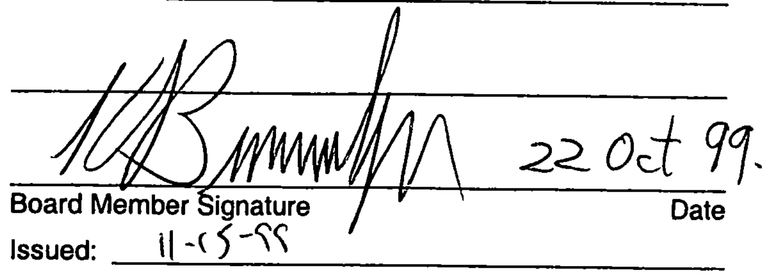
Application by Credentials based on: ______ Exam: USMLE

- ✓ Complete Application — Tentative Start Date Ak Residency Program
- ✓ Biographical Data Sheet; to Leslie —
- ✓ $200.00 Application Fee, Receipt # 687476
- ✓ $340.00 License Fee, Receipt # 687476
- ✓ Authorization to Release Records
- ✓ Verification of Exam Results
- ✓ Medical School Diploma Accredited ☑ Yes ☐ No, Unable to Locate
- ✓ Letter from Medical School Received 6/14/99
- ✓ All Internship/Residency Certificates Accredited ☑ Yes ☐ No, Unable to Locate
- ✓ Letter from Internship Program Received 6/22/99
- none Verification of License(s) in ______
- none Hospital Privileges Information Lost
- ✓ DEA Inquiry ______
- ✓ Federation Clearance See USMLE Scores
- ✓ AMA Data Sheet ______
- ✓ NPDB Sent ✓ Received ✓

______ Interview required ☐ Yes ☒ No
Interview with ______ on ______

✓ Approved	X Approved
___ Denied	___ Denied
Comments: ______	Comments: ______


9/28/99
Board Member Signature Date
License No. 4340


22 Oct 99.
Board Member Signature Date
Issued: 11-15-99

08-4390 (Rev. 3/99)

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