WORKSHEET FOR MEDICAL LICENSURE APPLICATIONS

APPLICANT NAME _____ DATE OF APPL. RECEIPT _____

		SCORES REC'D		
I.	METHOD OF LICENSURE			✓
	___ National Board Waiver			
	✓ Flex Waiver	88%		
	___ Reciprocity- _____			
	___ LMCC			
	___ Examination (NA. FLEX)			
II.	FEE RECEIVED	✓		
III.	PHOTOGRAPH(S) (1 for waiver/2 for exam)	✓*		
IV.	APPLICATION FORM			
	Affidavit	✓		✓
	Chronology	✓		✓
	Personal Data	✓		✓
V.	SUPPORTING DOCUMENTS			
	Transcripts or MED-5 (must show subjects, degree, date)	✓		✓
	Post Graduate Training	✓		✓
VI.	FOREIGN GRADUATES			
	ECFMG Standard Certificate OR Fifth Pathway	OR ✓		
VII.	BACKGROUND			
	States of Prior Licensure: (✓)OR( )__( )__( )__( )__	✓	See back	
	Hospital Privileges:			
	( )_____( )_____	NONE		
	( )_____( )_____			
	Residency Programs:			
	(✓) OHSU ( )_____ 7-81 to 6-85	✓		✓
	AMA Clearance MLD 3/13	✓		✓

ADMINISTRATION RECOMMENDATION: _____

FINAL ACTION: ___ Approved For Exam By _____ Date _____ BOARD REVIEW:
___ Denied for Exam By _____ Date
✓ Approved For Lic. By [illegible] Date 5-29-85

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 03-21-85
TIME: 10:07 AM

NAME: EASTERLING,THOS R, III M.D.
ADDRESS: U OR HLTH SCI CTR HOSP-CL , PORTLAND OR 97201
BIRTHPLACE: GREENSBORO,NC BIRTHDATE: 01/20/50
MEDICAL EDUCATION (SCHOOL YEAR):
UNIV OF NORTH CAROLINA SCH MED,CHAPEL HILL NC 27514 1981
NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE
LICENSES:
OR 1981
PHYSICIAN'S PROFESSIONAL ACTIVITIES:
RESIDENT
PRIMARY SPECIALTY: OBSTETRICS AND GYNECOLOGY
SECONDARY SPECIALTY: UNSPECIFIED
TERTIARY SPECIALTY: UNSPECIFIED
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE
MEMBER OF AMA: NOT MEMBER
NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE
PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE
CURRENT MEDICAL TRAINING: RESIDENT
HOSPITAL: THE OR HLTH SC CTR U-HOSP CL PORTLAND OR 97201
DATES OF TRAINING: 07/82-06/85
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED
INTERNSHIP:
HOSPITAL: THE OR HLTH SC CTR U-HOSP CL PORTLAND OR 97201
DATES OF TRAINING: 07/81-06/82
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED
RESIDENCY:
NONE REPORTED TO DATE
FELLOWSHIP:
NONE REPORTED TO DATE

 AMA FILES CHECKED SEE REVERSE

AMA PHYSICIAN PROFILE (CONTINUED)

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES

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; (3) THAT NO PROFILE INFORMATION WILL BE RELEASED, COPIED, EXTRACTED OR OTHERWISE USURPED FOR THE USE BY ANY OTHER PARTY, ENTITY, ORGANIZATION OR GOVERNMENT AGENCY; AND (4) THAT 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.

NAME: EASTERLING, THOMAS

ADDRESS: U S

BIRTHPLACE:

MEDICAL EDUCATION:

UNIV OF NOR

NATIONAL BOARD

LICENSES:

PHYSICIAN'S PRIMARY SPECIALTY

SECONDARY SPECIALTY BOARD

MEMBER OF AMA

NATIONAL SCIENTIFIC MEDICAL SOCIETIES:

PROFESSIONAL APPOINTMENT: NONE REPORTED TO DATE

CURRENT MEDICAL TRAINING: RESIDENT

HOSPITAL: THE OR HLTH SC CTR U-HOSP CL PORTLAND OR 97201

DATES OF TRAINING: 07\82-06\85

SPECIALTY: OBSTETRICS AND GYNECOLOGY

SPECIALTY: UNSPECIFIED

INTERNSHIP:

HOSPITAL: THE OR HLTH SC CTR U-HOSP CL PORTLAND OR 97201

DATES OF TRAINING: 07\81-06\82

SPECIALTY: OBSTETRICS AND GYNECOLOGY

SPECIALTY: UNSPECIFIED

RESIDENCY:

NONE REPORTED TO DATE

FELLOWSHIP:

NONE REPORTED TO DATE

THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.
2630 WEST FREEWAY, #138, FORT WORTH, TEXAS 76102-7199

TO: WASHINGTON

SUBJECT: FLEX Examination Grades For:

EASTERLING,THOMAS R
6403 SW 45TH AVE
PORTLAND, OR
97221

FIN 500120013
Birthdate 01/20/50
Date of Certification 05/07/85

It is certified that the named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following grades.

EXAMINATION DATE	12/81
FOR STATE	138
STATE ID #	ORE58
BASIC SCIENCE	
Anatomy	86
Physiology	88
Biochemistry	78
Pathology	90
Microbiology	85
Pharmacology	89
Behavioral Science	87
BASIC SCIENCE AVERAGE	86.42
CLINICAL SCIENCE	
Medicine	87
Surgery	88
Obstetrics	92
Public Health	91
Pediatrics	86
Psychiatry	85
CLINICAL SCIENCE AVERAGE	88.16
CLINICAL COMPETENCE AVERAGE	88.73
FLEX WEIGHTED AVERAGE	88.00

WE HAVE NO UNFAVORABLE
INFORMATION REGARDING
THE ABOVE NAMED PHYSICIAN

Bryant L. Galusha, M.D.

BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE PRESIDENT

THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE
CHAPEL HILL


EASTERLING,III,T.R

Name Thomas Rupert Easterling III

Date of Birth 1/20/50 Place of Birth Greensboro, N.C.

GRADING SYSTEM: Honors, Pass, Fail

FIRST YEAR
Dates: 22 August 1977 - 24 May 1978

Courses
Cell Biology
General Pathology
Gross Anatomy
Histology
Immunology
Introduction to Medicine
Microbiology-Virology
Neurobiology

RECEIVED
MAY 14 1985
DIVISION OF
PROFESSIONAL LICENSING

Summary Grade: _____ H

SECOND YEAR
Dates: 22 August 1978 - 18 April 1979

Courses
Nutrition
Cardiovascular-Respiratory System
Endocrine System
Gastrointestinal System
Hematology
Introduction to Psychiatry
Medicine and Society
Musculoskeletal System
Pathophysiology
Pharmacology
Physical Diagnosis
Radiobiology
Reproductive Biology
Skin and Connective Tissue
Urinary System

Summary Grade: _____ H

CLINICAL CLERKSHIPS	Dates
Medicine	14 May 1979 - 12 August 1979
Obstetrics-Gynecology	24 September 1979 - 4 November 1979
Surgery	5 November 1979 - 10 February 1980
Pediatrics	11 February 1980 - 23 March 1980
Psychiatry	24 March 1980 - 4 May 1980

Summary Grade: _____ H

ELECTIVES	Dates
Medi 411 - Infectious Diseases	2 June 1980 - 29 June 1980
Md/Pe 412 - Endocrinology	28 July 1980 - 24 August 1980
Md/Pe 413 - Nephrology	25 August 1980 - 21 September 1980
Anes 401 - AI Anesthesiology	29 September 1980 - 26 October 1980
FM 410 - Family Medicine Prcptship.	24 November 1980 - 21 December 1980
Medi 450 - Coronary Care Unit	5 January 1981 - 1 February 1981
Radi 401 - General Radiology	2 February 1981 - 1 March 1981
AHEC 402 - AI Medicine	2 March 1981 - 29 March 1981

Summary Grade: _____ H

M.D. Degree 17 May 1981
Date

MAY 07 1985
Date of Transcript

Connie M McMoore
Registrar

STATE OF WASHINGTON
DEPARTMENT OF LICENSING

Thomas R Easterling — 1/20/50
Name of applicant - Please print — Birthdate

I have applied for a license to practice medicine in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my postgraduate training program and return it directly to:

Division of Professional Licensing
Attention: Medical Section
P.O. Box 9649
Olympia, WA 98504

RECEIVED
APR 26 1985
DIVISION OF PROFESSIONAL LICENSING

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Board of Medical Examiners.

Thomas R Easterling MD
Signature of applicant

1. Is the applicant, or has the applicant been, engaged in postgraduate training in your program? Yes X No ___ If so, include dates, area of training (specialty). Internship and residency training 6/26/81 through 6/30/85

2. Briefly evaluate his/her competence and conduct during the program. If performance evaluations were conducted, PLEASE INCLUDE COPIES. Outstanding performance throughout residency

3. Has the program ever had cause to restrict, suspend or terminate, or ask for a voluntary resignation of his/her participation in the program? Yes ___ No X Please explain if yes

4. Is there anything in your files which could call into question his/her ability to safely practice medicine? Yes ___ No X Please explain if yes

PLEASE ATTACH ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION.

E. Paul Kirk

Name E. Paul Kirk, M.D.
Title Professor and Chairman
Hospital Oregon Health Sciences Univ.
Address 3181 S.W. Sam Jackson Pk. Rd.
Portland, OR 97201
Phone number (503) 225.8642

MED 657-034 Residency Ltr.
(R/4/83) wpc

April 17, 1985
6403 SW 45th Ave.
Portland, Ore. 97221

Dear Sirs:

Enclosed is a photograph to replace the one previously sent. I have requested FLEX and the University of North Carolina Medical School to send you the required information. Additionally, Oregon Health Sciences University will be forwarding certification of completion of postgraduate training.

Thankyou,

Thomas R. Easterling, M.D.

JOHN SPELLMAN
Governor

JOHN GONSALEZ
Director

STATE OF WASHINGTON

3/25/85 DEPARTMENT OF LICENSING

Highways-Licenses Building • Olympia, Washington 98504 • (206) 753-6918

Dr. Easterling

We are in receipt of your application for medical licensure in the State of Washington. As of this date, the following documents/items are necessary to complete your application:

( ) $____ fee in check or money order payable to Washington State Treasurer.

(X) Transcripts indicating coursework and degree awarded sent directly from your school or MED-5 form directly from the school.

( ) Verification of Standard ECFMG certificate directly from the issuing agency.

(X) Certification from all postgraduate training programs (including evaluations) directly to this office (include beginning and ending dates). _____
OHSU 7-81 to present

( ) Hospital letters directly from all hospitals where you have had privileges within the past five years (include beginning and ending dates). _____

( ) Verification of state licensures whether active or inactive directly from

( ) National Board (X) FLEX ( ) State Examination (include Basic Science scores from applicable state) scores directly from the issuing sources.

( ) Chronology: Account for all months from date of MD degree to the present. Specifically _____. Upon receipt of the completed chronology, additional documentation/information may be required.

( ) Affidavit incomplete (resubmit). Personal Data: _____

(X) Other: photograph

Upon receipt of the above, your application will be submitted for administrative review.

Donna Hull
Division of Professional Licensing
Medical Licensing Section
P. O. Box 9649
Olympia, WA 98504
(206) 753-2147

EASTERLING, THOMAS MD0002841 PAGE 9

EASTERLING, THOMAS

APPLICATION FOR: LICENSE TO PRACTICE

MEDICINE

22841 5-29-85

MONEY CTL. (6, 7, 8)

FEES

Medicine with Exam. $125.00
Medicine without Exam Exam. $75.00
Medicine (Having Wash Limited Lic)
With Exam $100.00
Without Exam $50.00

02G-070-252-0009

FOR VALIDATION ONLY

I 7739 70 030185 75.01

DEPARTMENT OF LICENSING
DIVISION OF PROFESSIONAL LICENSING
P.O. BOX 9649
OLYMPIA, WA 98504

Make remittance payable to:
STATE TREASURER

Application for licensure is made by: (Check one)

- ☐ National Board waiver.
- ☐ Reciprocity from (state) _____
- ☐ Washington Examination. (FLEX)
- ☐ L. M. C. C.
- ☒ Flex waiver.

FOR OFFICE USE ONLY

PROG (1)	TRANS (31)	PROF CODE (4		EXPIRATION DATE (9)	EXPT	STAT(11)	TYPE (12)
LA		252-	EASTERLING, THOMAS RUPERT 0 00-00-00				

KEY DATE (13)	CLASS (14)	ASSN (15)	BILLED AMOUNT (16)	SIGN	SPLIT	OTRD

2 - Personal Information -Credit card numbers, debit c...

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME (20) Easterling (Last) Thomas (First) Rupert (Middle)

ADDRESS (21) 6403 S.W. 45th Ave.

CITY (24) Portland STATE (25) Oregon ZIP (26) 97221 COUNTY (27) Multnomah

TELEPHONE NO. (39) 503-225-8311
Enter the number at which you can be reached during normal business hours.

SOCIAL SECURITY NUMBER (40) _____
1 - DOH Licensee Social Securit...
Requested for identification purposes only. Entering SSN is voluntary and is not required for licensing approval.

SEX (F or M) M DATE OF BIRTH January 20, 1950 (mo. day yr.)

BIRTHPLACE Greensboro, N.C. (City) Guilford (State) (County)

MEDICAL SPECIALTY Obstetrics abd Gynecology

EXAM DATE (42)
VOTER DIST. (46)
GRAD YR/SCH (48)

Medical School University of North Carolina Medical School Year Graduated 1981

INSTRUCTIONS

ALL APPLICANTS

(a) This application and supporting documents, should be filed with the Division of Professional Licensing at least thirty (30) days prior to the board meeting at which it is to be reviewed. (Or for Flex exam by April 1 for the June examination and October 1 for the December examination.)

(b) If additional space is required, attach separate (8½ x 11 inch) sheets indicating the section to which they refer.

(c) ALL APPLICATIONS MUST BE ACCOMPANIED BY APPLICABLE FEE. FEES ARE NON-REFUNDABLE.

JAN 1985

IDENTIFICATION

HEIGHT	WEIGHT
5'10"	160 lbs.
COLOR OF EYES	COLOR OF HAIR
brown	brown

Paste Photograph Here

Must be bust size taken within one year of application.

Enter date taken on photo and sign in ink across the bottom.

PERSONAL DATA

	YES	NO
1. Have you ever been called before any state or provincial licensing board for interrogation concerning any violation of the laws or regulations pertaining to the profession for which you are applying, or for unethical conduct?	☐	☒
2. Have you ever had a license to practice revoked, suspended, or restricted?	☐	☒
3. Have you ever been denied a license or the right to take an examination for licensing in any state, province, or country?	☐	☒
4. Have you ever had hospital privileges or medical society membership revoked, suspended, or restricted on grounds of unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment?	☐	☒

If the answer to any of the above questions is YES, enclose a letter naming the state, hospital or society, the date of the action, the cause, and the nature of the decision.

5. Have you ever been convicted of or plead guilty to a felony or misdemeanor?	☐	☒
6. Have you ever been convicted of a violation of any state or federal controlled substance act, or any drug or narcotic law?	☐	☒

If the answer to questions 5 or 6 is YES, please enclose a letter giving the date, jurisdiction, and nature of the conviction, as well as the sentence imposed. If still on parole or probation, provide the name and address of the supervising officer.

7. Have you ever used any legend drug, or controlled substance (including Schedule I) for other than therapeutic purposes?	☐	☒
8. Have you ever been addicted to or treated for addiction to or abuse of any controlled substance, drug or chemical?	☐	☒
9. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism?	☐	☒
10. Have you ever received psychiatric therapy or treatment or received treatment for a mental illness?	☐	☒
11. Are you presently suffering from any disability or illness (mental or physical) which could affect your ability to safely practice medicine?	☐	☒

If the answer to any of questions 7 through 11 is YES, please enclose a letter giving details of your use, condition or addiction. Include the name and address of the treating professional and/or institution.

12. List any malpractice settlement, award or payment as the result of a claim or action for damages alleged to have been caused by your incompetence or negligence in the practice of medicine. Include the nature of the case, date, and summarize care given. Enclose a copy of the original complaint and of the settlement or award.	☐	☒

FAILURE TO GIVE COMPLETE AND TRUE INFORMATION CONSTITUTES CAUSE FOR DENIAL OF YOUR APPLICATION FOR LICENSURE.

PREVIOUS REGISTRATION

Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current:

State or Other	Profession	Certificate		Permanent or Temporary	License Received By		Currently in Force
		Year	No.		Examination	Other	
Oregon	MD	1982	13289	perm.	exam		yes

PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience. Include college, university, medical or osteopathic school, and ALL periods of time from the date of graduation from medical or osteopathic school to the present, whether or not engaged in activities related to medicine.

List hospitals and local medical societies, including mailing addresses, in which you have had membership and/or privileges within the past five years. List internships and residency programs, including the city and state and any hospitals utilized in the training.

From ..... To Month, Day, Year		Name and Location of Institution, Place of Practice or Other	Degree or Certificate and Date Received, or Nature of Experience or Specialty
8-77	5-81	Univ. of North Carolina Medical School	M.D.
7-81	6-85	Oregon Health Sciences University	residency OB-GYN
		Good Samaritan Hosp. Portland, Oregon	
		Emannuel Hosp. Portland, Oregon	
		Bess Kaiser Hosp. Portland, Oregon	

Applicants for licensure by STATE RECIPROCITY must provide the following certification.

To be executed by the Secretary of the Board or Department of the State upon whose license the applicant relies for reciprocal registration in Washington. (To be completed only if license was obtained by written examination).

I certify that the aforesaid Thomas Rupert Easterling in his examination before the Oregon Board of Medical Examiners

of this state attained a general average of _____ percent (or FLEX WEIGHTED AVERAGE OF 88 percent) and the following marks in the subjects named:

Subject	Percent	Subject	Percent
anatomy	88	behavioral sciences	87
physiology	88	medicine	87
biochemistry	78	surgery	88
pathology	90	obstetrics	92
microbiology	85	public health	91
pharmacology	89	pediatrics 86 psychiatry	85

If FLEX examination please provide the following averages for each day.

DAY I BASIC SCIENCES 86.42 DAY II CLINICAL SCIENCES 88.16 DAY III CLINICAL COMPETENCE 88.73

I do further certify that certificate number 13289 to practice medicine

was issued to said applicant on the 27th day of July, 1982, upon the following qualifications:

graduation from U. of North Carolina School of Medicine and other Oregon requirements

and said certificate has not been revoked or suspended and that, from the records now on file in this office, I believe his to be of good moral character and worthy of professional recognition, and recommended him to the Division of Professional Licensing of the State of Washington as a fit and proper person to receive recognition as an applicant for a reciprocity certificate permitting him to practice medicine

In testimony thereof, witness my hand and seal this 13th day of February, 19 85

Jan Baggerstas
License Administrator
SECRETARY OF THE Oregon Board of Medical Examin

[SEAL]

POST OFFICE ADDRESS 317 S.W. Alder St., #1002
Portland, Oregon 97204

AFFIDAVIT

I, Thomas Rupert Easterling, being first duly sworn, depose and say that I am the
print or type full name of applicant

person described and identified; that I am of good moral character; that I have not engaged in any of the acts prohibited by the statutes of the State of Washington; that I am the person named in the diploma which accompanies this applciation; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentations.

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

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice in the State of Washington.

Thomas R Easterling
applicant's signature

Subscribed and sworn to before me this 13th day of February, 19 85

Donna L. Miles
Notary Public for the state of Oregon

[SEAL]

Residing at Lake Oswego, Oregon 97034

MED 657-020 Med. App.
(H/7/84) Pg. 4 of 4 -375-

Application File_1335212.pdf redacted on: 3/23/2020 14:55

Redaction Summary (2 redactions)

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2 Privilege / Exemption reasons used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (1 instance)
2 -- "Personal Information -Credit card numbers, debit card numbers, electronic check numbers, card expiration dates, or bank or other financial information as defined in RCW 9.35.005 including social security numbers - RCW 42.56.230(5)" (1 instance)

Redacted pages:

Page 10, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 10, Personal Information -Credit card numbers, debit card numbers, electronic check numbers, card expiration dates, or bank or other financial information as defined in RCW 9.35.005 including social security numbers - RCW 42.56.230(5), 1 instance