STATE OF WASHINGTON

DEPARTMENT OF LICENSING

P.O. BOX 9649 OLYMPIA, WA 98504-8001

FOR VALIDATION ONLY 02G-070-252-0009

8114 000 070 091488 150.00

MAKE REMITTANCE PAYABLE TO: STATE TREASURER

APPLICATION FOR LICENSE TO PRACTICE MEDICINE

FOR OFFICE USE ONLY		
CERTIFICATE NO. 25961	ISSUE DATE 10-17-88	EXPIRATION DATE 3-27-89

APPLICATION FOR LICENSURE IS MADE BY: (check one)

- [x] NATIONAL BOARD WAIVER
- [ ] ENDORSEMENT OF STATE EXAMINATION
- [ ] FLEX EXAMINATION WAIVER
- [ ] LMCC (must have been obtained after 1969)
- [ ] FLEX EXAMINATION

State ILLINOIS DATE OF EXAMINATION REQUESTED (month and year) 3/5/86

FOR OFFICE USE ONLY

PROG (1)	TRANS (3)	PROF CODE (4)	PIC/CIC (5)		EXPIRATION DATE (9)	EXPT (10)	STAT (11)	TYPE (12)
LA	14	252-09					/	/

KEY DATE (13)	CLASS (14)	ASSN (15)	BILLED AMOUNT (16)	SIGN	SPLIT	QRTD
3-27-59			165.00			

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S NAME (20) PONTO (LAST) KATHRYN (FIRST) LOUISE (MIDDLE)

ADDRESS (21) 156 GAGE RD

CITY (24) RIVERSIDE STATE (25) IL ZIP (26) 60546 COUNTY (27) COOK

TELEPHONE NUMBER (39) WORK 702-6127 HOME (312)447-6417
WHERE YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.

SOCIAL SECURITY NUMBER (40) 22 Licensee SSN
REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND IS NOT REQUIRED FOR LICENSING APPROVAL.

SEX (F or M) F BIRTHDATE 03 (MO.) - 27 (DAY) - 59 (YR.)

BIRTHPLACE MILWAUKEE (CITY), WI (STATE) COUNTY

MEDICAL SPECIALITY OBSTETRICS/GYNECOLOGY

MEDICAL SCHOOL UNIVERSITY OF CHICAGO (NAME/COUNTRY) YEAR GRADUATED 1985

FOR OFFICE USE ONLY	
EXAM DATE (42)	
VOTER DIST. (46)	
GRAD. YR./SCH. (48)	

HAVE YOU PREVIOUSLY APPLIED FOR A WASHINGTON STATE MEDICAL LICENSE OR LIMITED LICENSE? ☐ YES ☒ NO

LIST OTHER NAME(S) THAT APPEAR ON DOCUMENTS OR CREDENTIALS

FOLLOW CAREFULLY ALL INSTRUCTIONS IN GENERAL INSTRUCTIONS—ALL APPLICANTS. IT IS THE RESPONSIBILITY OF THE APPLICANT TO SUBMIT OR REQUEST TO HAVE SUBMITTED, ALL REQUIRED SUPPORTING DOCUMENTS.

8-28

IDENTIFICATION

HEIGHT	WEIGHT
5' 4"	120 #
COLOR OF EYES	**COLOR OF HAIR**
BLUE	LT BROWN

PERSONAL DATA

	YES	NO
1. HAVE YOU EVER HAD A LICENSE TO PRACTICE MEDICINE SUSPENDED, REVOKED, RESTRICTED OR DENIED IN ANY STATE, FEDERAL OR FOREIGN JURISDICTION?	☐	☒
2. HAVE YOU EVER HAD HOSPITAL PRIVILEGES, OR MEDICAL SOCIETY MEMBERSHIP REVOKED, SUSPENDED OR RESTRICTED ON GROUNDS OF UNPROFESSIONAL CONDUCT, INCOMPETENCE, NEGLIGENCE, OR UNSAFE PRACTICES?	☐	☒
3. HAVE YOU EVER BEEN CONVICTED OF ANY GROSS MISDEMEANOR OR FELONY RELATING TO THE PRACTICE OF MEDICINE?	☐	☒
4. HAVE YOU EVER BEEN THE RECIPIENT OF ANY DISCIPLINARY ACTION, INCLUDING REPRIMAND OR HAVE YOU EVER ENTERED A STIPULATED AGREEMENT OR AGREED TO DISCONTINUE AN ACT ALLEGED AS A VIOLATION OF LAW OR AN UNSAFE PRACTICE?	☐	☒

IF RESPONSE TO 1, 2, 3, OR 4 IS AFFIRMATIVE, ATTACH CERTIFIED COPIES OF ORDERS, STIPULATIONS, AGREEMENTS, CHARGES, JUDGEMENTS, SENTENCE, FINDINGS AND NATURE OF DECISIONS. IF ON PAROLE OR PROBATION, INCLUDE A LETTER FROM THE SUPERVISING OFFICER INDICATING PROGRESS.

	YES	NO
5. HAVE YOU EVER BEEN FOUND GUILTY OF THE VIOLATION OF ANY DRUG LAW, OR PRESCRIBING CONTROLLED SUBSTANCES FOR YOURSELF?	☐	☒
6. HAVE YOU EVER BEEN INVOLVED IN THE POSSESSION, USE, PRESCRIPTION FOR USE, OR DIVERSION OF CONTROLLED SUBSTANCES OR LEGEND DRUGS IN ANY OTHER THAN FOR LEGITIMATE OR THERAPEUTIC PURPOSES?	☐	☒
7. HAVE YOU EVER VOLUNTARILY SUBMITTED OR BEEN REQUIRED TO SUBMIT FOR TREATMENT FOR ALCOHOL DEPENDENCY?	☐	☒

IF RESPONSE TO 5, 6 OR 7 IS AFFIRMATIVE, ATTACH CERTIFIED COPIES OF CHARGES, SENTENCE, ORDER, STIPULATION AND/OR DISPOSITION. ALSO INCLUDE LETTERS FROM THE TREATING PROFESSIONAL AND/OR INSTITUTION STATING DETAILS OF CONDITION OR ADDICTION, TREATMENT AND PROGNOSIS.

	YES	NO
8. HAVE YOU EVER RECEIVED TREATMENT FOR A MENTAL ILLNESS?	☐	☒
9. HAVE YOU EVER BEEN RELEASED FROM OR RESTRICTED IN A MEDICAL PROGRAM BECAUSE OF A MENTAL CONDITION OR ILLNESS?	☐	☒

IF RESPONSE TO 8 OR 9 IS AFFIRMATIVE, ATTACH CERTIFIED COPIES OF DIAGNOSIS, TREATMENT, OR PROGNOSIS ALONG WITH LETTERS FROM ANY TREATING PHYSICIAN AND/OR PROFESSIONAL STATING DETAILS OF CONDITION AND PROGNOSIS.

	YES	NO
10. HAVE YOU EVER VOLUNTARILY GIVEN UP PRIVILEGES, A LICENSE TO PRACTICE, OR AGREED TO RESTRICT YOUR PRACTICE IN LIEU OF OR TO AVOID FORMAL ACTION? (IF YES, PROVIDE A NOTARIZED STATEMENT OF EXPLANATION)	☐	☒
11. HAVE YOU BEEN NAMED IN ANY MALPRACTICE SUITS ALLEGING YOUR INCOMPETENCE OR NEGLIGENCE IN THE PRACTICE OF MEDICINE? IF YES, INCLUDE THE NATURE OF THE CASE, DATE, AND SUMMARIZE CARE GIVEN. ENCLOSE A COPY OF THE ORIGINAL COMPLAINT AND SETTLEMENT OR FINAL DISPOSITION. IF PENDING, INDICATE THE STATUS.	☐	☒

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

EDUCATION AND EXPERIENCE

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY)

SCHOOLS ATTENDED—LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.	NUMBER OF YEARS ATTENDED	ATTENDANCE				DIPLOMA OR DEGREE OBTAINED QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH
		ENTRANCE		LEAVING		
		CLASS/ GRADE	DATE MO./YR.	CLS/GRD CMPLT.	DATE MO./YR.	
Medical Education (List all Medical Schools Attended)						
UNIVERSITY OF CHICAGO	4	1st YR	9/81	4 YRS	6/85	M.D. DOCTOR OF MEDICINE
Post-Graduate Training (List all programs attended)						
UNIVERSITY OF CHICAGO - OB/GYN RESIDENT	4	1st YR	7/85	4th YR	7/89	

IN CHRONOLOGICAL ORDER LIST ALL PROFESSIONAL EXPERIENCE RECEIVED SINCE GRADUATION FROM MEDICAL SCHOOL TO THE PRESENT. (EXCLUDE ACTIVITIES LISTED UNDER OTHER SECTIONS.) (ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY)

INDICATE NATURE OF EXPERIENCE OR PRACTICE	INCLUSIVE DATES OF EXPERIENCE	
	BEGINNING MO./YR.	ENDING MO./YR.
UNIV OF CHICAGO - RESIDENT OB/GYN ALL EXPERIENCE IN RESIDENCY	7/85	7/89

FIFTH PATHWAY

(ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY)

NAME AND LOCATION OF MEDICAL SCHOOL	NAME AND LOCATION OF HOSPITAL	INCLUSIVE DATES ATTENDED

PLEASE LIST HOSPITALS WHERE PRIVILEGES HAVE BEEN GRANTED WITHIN THE PAST FIVE (5) YEARS.

(FOR LOCUM TENENS, ENTER ONLY THOSE OF A 30 DAY OR LONGER DURATION. SEE INSTRUCTIONS REGARDING REPORTS AND VERIFICATION.) (ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY.)

NOTE: IF ADDITIONAL 8½x11 SHEET(S) ATTACHED, PLEASE LABEL AS TO SUBJECT, i.e., FIFTH PATHWAY.

LICENSES IN OTHER STATES/COUNTRIES

List all licenses to practice medicine obtained in other states or provinces of Canada. (Include whether active or inactive).

STATE, COUNTRY OR PROVINCE	DATE LICENSE ISSUED	NUMBER	BASIS OF LICENSURE		STATUS OF LICENSE ACTIVE/INACTIVE	ANY LIMITATIONS ON LICENSE
			EXAMINATION (DATE PASSED)	ENDORSEMENT		
ILLINOIS	4/87	036-074539	3/86	NATIONAL BOARDS	ACTIVE	NONE

AFFIDAVIT

I, KATHRYN LOUISE PONTO, being first duly sworn, depose and say that
PRINT OR TYPE FULL NAME OF APPLICANT

I am the 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 documents presented in support of this application; that I am the lawful holder of a medical 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.

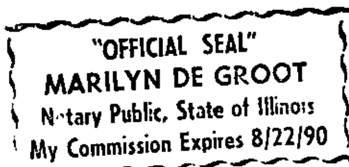
I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, 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

Applicant's Signature Kathryn Louise Ponto

Subscribed and sworn to before me this first

day of September, 1988

(SEAL)


"OFFICIAL SEAL"
MARILYN DE GROOT
Notary Public, State of Illinois
My Commission Expires 8/22/90

Notary Public for the state of Illinois

Residing at 14976 Markham Dr. Harvey, Il

STATE OF WASHINGTON

MEDICAL APPLICATION CHECKLIST

NAME Panto, Kathlyn Louise DOB 3/27/59

15.00

☑ Fee Rec'd ☑ Photo ☑ Affidavit

☑ Personal Data: Yes Response To #_____/ _____/ _____/ _____/

☑ Chronology: Missing _____ TO _____/ _____ TO _____/ _____ TO _____.

TRAINING

☑ U.S. ☐ Canada ☐ Offshore ☐ Fifth Pathway ☐ Foreign

☐ ECFMG Cert (Indefinite)

☑ AMA Profile ☑ MDB Clearance

REQUESTING LICENSURE BY ☐ Flex Exam ☐ June_____ ☐ December_____.

☐ Flex Waiver: Scores _____/ _____/ _____. OR Wtd Ave._____.

☑ Nat'l. Board Waiver: Scores 79.9/ _____/ _____.

☐ State Const. Exam From _____. Scores _____/ _____/ _____.

☐ Reciprocity From _____ ☐ LMCC Cert. (After 1969).

EDUCATION

Medical School University of Chicago

M.D. Degree Date 1985 ☑ Transcript ☐ Translation.

POST GRADUATE TRAINING ☐ One year prior to 1985 ☑ Two years after 1985

☑ Univ. of Chicago 7-85 to Present ☑ Verif. ☑ Eval.

☐ _____ ☐ Verif. ☐ Eval.

☐ _____ ☐ Verif. ☐ Eval.

☐ _____ ☐ Verif. ☐ Eval.

☐ _____ ☐ Verif. ☐ Eval.

☐ Fifth Pathway Verif. and Eval.:

STATE(S)/PROVINCES/COUNTRIES OF LICENSURE

☑ Il ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____.

HOSPITAL PRIVILEGES (EXPERIENCE)

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

OFF-SHORE CLERKSHIPS

☐ In U.S. (Enter institutions above under PGT) ☐ Syllabus ☐ Contract

☐ State Board verif. in states(s) of _____ _____ _____.

☐ In Offshore Med. School ☐ Verif. of subject areas

☐ Eval. from Med School Dean ☐ Verif. from local jurisdiction.

ACTION OCT 17 1988

Refer to PPMD Date _____ Ret'd. Date _____

Approved ☑ By D. Tauberman MD Date 10/4/88

Disapproved ☐ By _____ Date _____

STATE OF WASHINGTON

MEDICAL APPLICATION CHECKLIST

NAME Panto, Kathryn Louise DOB 3/27/59

15.00

☑ Fee Rec'd ☑ Photo ☑ Affidavit

☑ Personal Data: Yes Response To # ____ / ____ / ____ / ____

☑ Chronology: Missing ____ TO ____ / ____ TO ____ / ____ TO ____.

TRAINING

☑ U.S. ☐ Canada ☐ Offshore ☐ Fifth Pathway ☐ Foreign

☐ ECFMG Cert (Indefinite)

☑ AMA Profile ☑ MDB Clearance

REQUESTING LICENSURE BY ☐ Flex Exam ☐ June ____ ☐ December ____.

☐ Flex Waiver: Scores ____ / ____ / ____. OR Wtd Ave. ____.

☑ Nat'l. Board Waiver: Scores 79.9 / ____ / ____.

☐ State Const. Exam From ____. Scores ____ / ____ / ____.

☐ Reciprocity From ____ ☐ LMCC Cert. (After 1969).

EDUCATION

Medical School University of Chicago

M.D. Degree Date 1985 ☑ Transcript ☐ Translation.

POST GRADUATE TRAINING ☐ One year prior to 1985 ☑ Two years after 1985

☑ Univ. of Chicago 7-85 to Present ☑ Verif. ☑ Eval.

☐ ____ ☐ Verif. ☐ Eval.

☐ ____ ☐ Verif. ☐ Eval.

☐ ____ ☐ Verif. ☐ Eval.

☐ ____ ☐ Verif. ☐ Eval.

☐ Fifth Pathway Verif. and Eval.:

STATE(S)/PROVINCES/COUNTRIES OF LICENSURE

☑ Il ☐ ____ ☐ ____ ☐ ____ ☐ ____ ☐ ____.

HOSPITAL PRIVILEGES (EXPERIENCE)

☐ ____ ☐ ____

☐ ____ ☐ ____

☐ ____ ☐ ____

OFF-SHORE CLERKSHIPS

☐ In U.S. (Enter institutions above under PGT) ☐ Syllabus ☐ Contract

☐ State Board verif. in states(s) of ____ / ____ / ____.

☐ In Offshore Med. School ☐ Verif. of subject areas

☐ Eval. from Med School Dean ☐ Verif. from local jurisdiction.

ACTION

Refer to PPMD. Date OCT 17 1988 Ret'd. Date ____

Approved ☐ By ____ Date ____

Disapproved ☐ By ____ Date ____

MED-657-005 MED. APPL. CHECKLIST (N/11/87)

*** REQUEST FOR PAYMENT ***

FOR : PHYSICIAN & SURGEON

MAKE CHECK, BANKDRAFT OR MONEY ORDER PAYABLE TO: STATE TREASURER
RETURN THIS NOTICE WITH REMITTANCE TO: STATE OF WASHINGTON
DIV. OF PROFESSIONAL LICENSING
P.O. BOX 9649
OLYMPIA, WASHINGTON 98504

PONTO,KATHRYN LOUISE
156 GAGE RD
RIVERSIDE IL 60546

FEE DUE IS $15.00
EXP DATE __/__/__

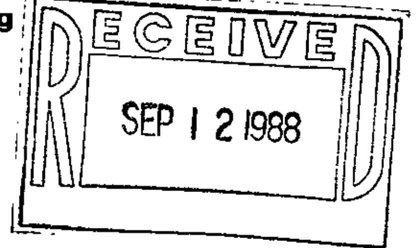
THE ADMINISTRATOR

ADP-153 09-20-88 252-09 17 Banking Info SPLIT 0 1 LZ-81 LF 14

0004 000 070 101188 1500

PAY TO THE ORDER OF
OLYMPIA BRANCH
RAINIER NATIONAL BANK
FOR DEPOSIT ONLY
WASHINGTON STATE TREASURER
DEPARTMENT OF LICENSING 240
0041399260

Department of Licensing
Health Care Licensing
1300 South Quince
Olympia, WA 98504



Date: 8-30-88

Dear Ms. Hubbard:

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

NAME: Kathryn Louise Ponto, MD

SSN #: 22 Licensee SSN

MEDICAL SCHOOL OF GRADUATION: University of Chicago

YEAR OF GRADUATION: 1985

BIRTHDATE: 3-27-59

RESPONSE:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

SEP 16 1988

Bryant L. Galusha, M.D.

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

MED-657-072 MEDICAL DISCIPLINARY REQUEST (R/2/87)

Illinois Department of Professional Regulation

Stephen F. Selcke
Director

James R. Thompson
Governor

CERTIFICATION

September 30, 1988

RECEIVED
OCT 07 1988
LICENSING DIVISION

Department of Licensing
Highways-Licenses Building
Olympia, WA 98504

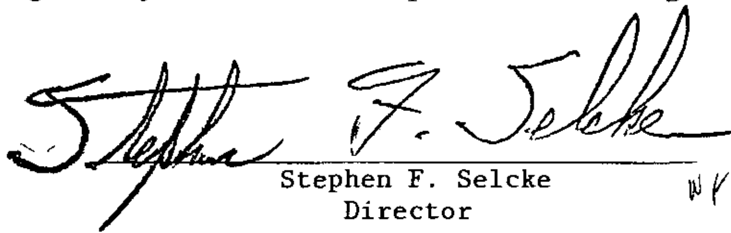
I, Stephen F. Selcke, do hereby certify that I am the Director of the Department of Professional Regulation, a department of the government of the State of Illinois; that I am the keeper of the records of the Department of Professional Regulation and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	KATHRYN L. PONTO
WAS ISSUED LICENSE NO:	036-74539
ON:	03/02/87
TO PRACTICE AS A:	LICENSED PHYSICIAN & SURGEON
LICENSED BY:	ACCEPTANCE OF NATIONAL BOARD
CURRENT LICENSURE STATUS IS:	ACTIVE
CURRENT LICENSE EXPIRES:	07/31/90

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED.

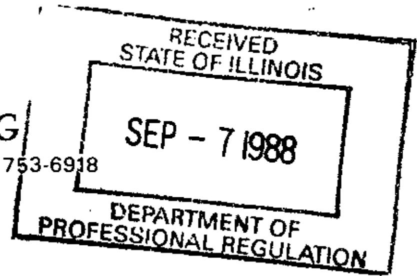
The information above is the only certification information provided by this Department. If other information is needed, it must be obtained from the above-named individual or the agency or institution which initially generated the information. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Department.

For detailed information regarding the type and length of discipline, if any, submit a written request to the Regulatory Unit at the Department's Chicago office.



Stephen F. Selcke
Director

SEAL



STATE OF WASHINGTON
DEPARTMENT OF LICENSING
Highways-Licenses Building • Olympia, WA 98504 • (206) 753-6918

TO: Medical Licensing Board

RE: Verification of License

I am applying for a license to practice medicine in the State of Washington and before my application can be reviewed, verification of my license status in your state is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. Thank you for your attention to this matter.

KATHRYN LOUISE PONTO
NAME OF APPLICANT (PRINT OR TYPE)

3-27-59
(BIRTHDATE)

Kathryn Louise Ponto, MD
SIGNATURE OF APPLICANT

TO: Department of Licensing
Division of Professional Licensing
Health Care Licensing — Physicians and Surgeons
P.O. Box 9649
Olympia, WA 98504

This is to verify that ______________________ was issued license
(APPLICANT NAME)

number ______________ on ______________ on the basis of National Boards
(DATE OF ISSUE)

______________ ; state constructed exam ______________ (please provide subjects

and grades); FLEX exam ______________ ; Other (specify) ______________ ; or by

reciprocity from the state of ______________ .

Have any complaints been lodged against the license? Yes ________ No ________ .

Is there currently any investigation in process regarding the license?

Yes ________ No ________ .

Has any disciplinary activity taken place regarding this license? Yes ________ No ________ .

If yes, please provide any information and documentation which may be released, i.e., charges and final disposition.

S E A L

SIGNATURE

TITLE

STATE BOARD

DATE

MED-657-008 STATE LETTER (R/10/87)

STATE OF WASHINGTON
DEPARTMENT OF LICENSING
Highways-Licenses Building • Olympia, WA 98504 • (206) 753-6918

RECEIVED
SEP 22 1988
DIVISION

TO: Medical Post-Graduate Training Program Director
RE: Verification/Evaluation of Training

I am applying for a license to practice medicine in the State of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. Thank you for your attention to this matter.

KATHRYN LOUISE PONTO — *Applicant (Please print or type)*

3-27-59 — *(Birthdate)*

Kathryn Louise Ponto, MD — *Signature of Applicant*

TO: Department of Licensing
Division of Professional Licensing
Health Care Licensing
P.O. Box 9649
Olympia, WA 98504

1. The above individual is or was engaged in post-graduate training in our program from July, 1985 (*Beginning Date*) TO July, 1989 (*Ending Date*), In the field of obstetrics and gynecology.

2. Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evauations conducted.) Dr. Ponto is an excellent Resident and a very knowledgeable gynecologist and obstetrician.

3. Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? YES ______ NO ✓ .If yes, please explain: ______

4. Is there anything in the participant's file which would indicate he/she would be unable to safely practice medicine? YES ______ NO ✓ . If yes, please provide documentation.

5. We would appreciate any other documentation which you feel would assist us in the evaluation process.

Thank you.

NAME Arthur L. Herbst, M.D. [signature]
TITLE Chairman, Dept. of OB/GYN
HOSPITAL The University of Chicago
(Please type or print)
ADDRESS 5841 S. Maryland Avenue
Chicago, Illinois 60637
DATE September 12, 1988

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Kathryn L. Ponto, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa.
07/01/86 Certificate # 305089

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from UNIVERSITY OF CHICAGO in JUNE 1985 and whose birth date is 03/27/1959 This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/83		
Anatomy, incl. histology and embryology	595	87
Physiology	355	71
Biochemistry	565	85
Pathology	405	75
Microbiology, incl. immunology	480	79
Pharmacology and Materia Medica	370	72
Behavioral Sciences	415	75
TOTAL TEST (Minimum Passing Score 380/75)	450	77
Part II passed 09/84		
Internal medicine and the medical specialties	390	77
Surgery and the surgical specialties	475	81
Obstetrics and Gynecology	610	88
Public Health and Preventive Medicine	475	81
Pediatrics	560	85
Psychiatry	500	82
TOTAL TEST (Minimum Passing Score 290/75)	500	82
PART III passed 03/86		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	460	80.7
GENERAL AVERAGE (Parts I, II, and III Scale Score)		79.9

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Melanie Valente
Secretary for Certification

SEAL

09/16/88
Date

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES DATE: 09-13-88
DEPARTMENT OF DATA RELEASE SERVICES TIME: 1:56 PM

NAME: PONTO, KATHRYN LOUISE, M.D.
ADDRESS: 42 LAWTON APT NO 1
RIVERSIDE IL 60546
BIRTHPLACE: MILWAUKEE, WI
BIRTHDATE: 03/27/59
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL
UNIV OF CHICAGO, PRITZKER SCH OF MED, CHICAGO IL 60637
YEAR OF GRADUATION: 1985
LICENSES (INITIAL YEAR GRANTED BY STATE):
IL 1987
NATIONAL BOARD CERTIFICATION: 1986
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: RESIDENT
SELF DESIGNATED SPECIALTIES
PRIMARY: OBSTETRICS AND GYNECOLOGY
SECONDARY: UNSPECIFIED
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: RESIDENT
HOSPITAL: UNIV OF CHICAGO MED CTR CHICAGO IL 60637
DATES OF TRAINING: 07/86-06/89 -- (BEING RE-CONFIRMED)
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: INTERN
HOSPITAL: UNIV OF CHICAGO MED CTR CHICAGO IL 60637
DATES OF TRAINING: 07/85-06/86 -- (CONFIRMED)
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED

FELLOWSHIP: NONE REPORTED TO DATE

THE FOLLOWING IS HISTORICAL. CHECK WITH PRIMARY SOURCES FOR CURRENT STATUS:

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

COPYRIGHT 1988 AMERICAN MEDICAL ASSOCIATION. SEE REVERSE.***AMA FILES CHECKED

IT IS MUTUALLY AGREED BETWEEN THE AMERICAN MEDICAL ASSOCIATION (AMA) ANC 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.

THE UNIVERSITY OF CHICAGO
The Office of the University Registrar

CHICAGO, ILLINOIS 60637

NOTE: A transcript is official when it bears the University Registrar's seal and signature.

OFFICIAL ACADEMIC RECORD

STUDENT NAME: KATHRYN LOUISE PONTO

BIRTH PLACE	BIRTH DATE	STUDENT NUMBER
MILWAUKEE WISCONSIN	03/27/59	82-82-37

PREVIOUS INSTITUTIONS ATTENDED:
MIAMI UNIVERSITY
OXFORD, OHIO 1977-79
B.S. UNIVERSITY OF WASHINGTON
SEATTLE, WASHINGTON 1981

AUT 81 GRAD LEVEL ONE MEDICINE

ANAT	300	HUMAN MORPHOLOGY	100	P
ANAT	301	HUMAN MORPHOLOGY	100	P
BIOCH	311	ADVANCED GENERAL BIOCHEMISTRY	100	P
CLINIC	300	CLINICAL ORIENTATION PROGRAM	025	P
CLINIC	390	INTRODUCTION TO THE PATIENT	025	P

WIN 82 GRAD LEVEL ONE MEDICINE

ANAT	302	HUMAN MORPHOLOGY	100	P
CLINIC	300	CLINICAL ORIENTATION PROGRAM	025	P
SOCMED	309	SOCIAL,ETHICAL ISSUES IN MED	025	P
MEDBIO	302	INFECTION AND IMMUNITY	100	P
MEDBIO	303	CELLULAR AND ORGAN PHYSIOLOGY	100	P

SPR 82 GRAD LEVEL ONE MEDICINE

MEDBIO	304	ORGAN/PHYSIOL ENDOCRIN	100	P
MEDBIO	305	NEUROBIOLOGY	100	P
PEDS	418	READINGS IN PEDIATRICS	100	P
PSYCHI	301	INTRO BEHAV SCI/PSYCHOPATHOLOG	025	P

AUT 82 GRAD LEVEL TWO MEDICINE

CLNUTR	350	HUMAN NUTRITION	100	P
MEDBIO	306	CELL PATHOLOGY	100	P
MEDBIO	315	MEDICAL STATISTICS	050	P
PHAPHY	306	PHARMACOLOGY	050	P

WIN 83 GRAD LEVEL TWO MEDICINE

CLINIC	301	HIST TAKING/PHYSICAL DIAGNOSIS	050	P
MEDBIO	307	CLINICAL PATHOPHYSIOLOGY	250	P

SPR 83 GRAD LEVEL TWO MEDICINE

GENET	339	MEDICAL GENETICS	050	P
CLINIC	301	PHYSICAL DIAGNOSIS-HIST TAKING	050	P
MICROB	331	MICROORGANISMS INFECTIOUS DIS	100	P
OPHTH	301	CLINICAL OPHTHALMOLOGY	025	P
PHAPHY	307	CLINICAL PHARMACOLOGY	050	P
RADIOL	310	FDMTLS DIAGNOSTIC RADIOLOGY	050	P

SUM 83 GRAD LEVEL TWO MEDICINE

MED	303	JR EXTERNSHP INPT MED SERVICES	300	P

AUT 83 GRAD LEVEL TWO MEDICINE

OB/GYN	303	EXTERNSHIP IN HOSPITAL	150	P
PSYCHI	303	CLERKSHIP IN PSYCHIATRY	150	P

RECEIVED
SEP 13 1988
DIVISION

SEP - 9 1988

Issued to :

Department of Licensing
Health Care Licensing
1300 South Quince
P.O. Box 9649
Olympia, WA 98504

THIS IS A TRUE COPY OF THE STUDENT'S SCHOLASTIC RECORD AT THE UNIVERSITY OF CHICAGO. SEE ENCLOSED KEY TO TRANSCRIPTS.

Maxine H. Sullivan
MAXINE SULLIVAN, UNIVERSITY REGISTRAR

A BLACK & WHITE TRANSCRIPT IS NOT AN ORIGINAL.
BROWN STAINS INDICATE UNAUTHORIZED CHANGES
THE WORD COPY APPEARS IF COLOR COPIED.

THE UNIVERSITY OF CHICAGO

The Office of the University Registrar

CHICAGO, ILLINOIS 60637

NOTE: A transcript is official when it bears the University Registrar's seal and signature.

OFFICIAL ACADEMIC RECORD

STUDENT NAME		
KATHRYN LOUISE PONTO		
BIRTH PLACE	BIRTH DATE	STUDENT NUMBER
MILWAUKEE WISCONSIN	03/27/59	82-82-37

WIN 84 GRAD LEVEL TWO MEDICINE

SURG	303	EXTERNSHIP IN HOSPITAL	300	P

SPR 84 GRAD LEVEL TWO MEDICINE

MED	304	DERMATOLOGY EXTERNSHIP IN MED	050	P
PEDS	303	JUNIOR EXTERNSHIP	200	P
SURG	330	BASIC ENT	050	P

SUM 84 GRAD LEVEL TWO MEDICINE

EM MED	306	SR CLERKSHIP IN EMERGENCY MED	125	B
OB/GYN	361	OBSTETRIC-BIRTH ROOMS	050	P
OB/GYN	366	GYN ONCOLOGY SERVICE	125	P

AUT 84 GRAD LEVEL TWO MEDICINE

MED	321	STDY UNIV OR MED CTR/U C CLIN	125	P
MED	358	CLINICAL CHEST CONSULTS SERV	125	P
PATHOL	357	ROTATION IN SURGICAL PATHOL	050	A

WIN 85 GRAD LEVEL TWO MEDICINE

MED	321	STDY UNIV OR MED CTR/U C CLIN	100	P
MED	341	CARDIOLOGY-CLIN HEMODYNAMICS	100	P
MED	491	PATHOPHYSIOL CRITICAL ILLNESS	100	P

SPR 85 GRAD LEVEL TWO MEDICINE

EM MED	307	ADVANCED CARDIAC LIFE SUPPORT	025	P
MED	486	DRUG USE IN CLINICAL PRACTICE	100	P
OB/GYN	403	ADVANCED READING IN OB/GYN	050	P
RADIOL	367	DIAGNOSTIC RADIOLOGY	125	P

DEGREE MD DOCTOR OF MEDICINE
MEDICINE
AWARDED JUNE 1985

*** END OF TRANSCRIPT ***

The Medical School employs a strictly "Pass" or "Fail" grading system with no "Honors" designation in all required courses.

* THE FAMILY EDUCATION RIGHTS AND PRIVACY ACT OF 1974, *
* AS AMENDED, PROHIBITS THE RELEASE OF INFORMATION FROM *
* THIS TRANSCRIPT WITHOUT THE PRIOR WRITTEN CONSENT OF *
* THE STUDENT TO WHOM IT PERTAINS. *

SEP - 9 1988

THIS IS A TRUE COPY OF THE STUDENT'S SCHOLASTIC RECORD AT THE UNIVERSITY OF CHICAGO
SEE ENCLOSED KEY TO TRANSCRIPTS

MAXINE SULLIVAN, UNIVERSITY REGISTRAR

A BLACK & WHITE TRANSCRIPT IS NOT AN ORIGINAL.
BROWN STAINS INDICATE UNAUTHORIZED CHANGES
THE WORD COPY APPEARS IF COLOR COPIED.

Redaction Date: 9/25/2020 2:42:03 PM

Redaction Log

Total Number of Redactions in Document: 3

Redaction Reasons by Page

Page	Reason	Description	Occurrences
1	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1
7	17 Banking Info	RCW 42.56.230 (5): 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	1
9	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1

Redaction Date: 9/25/2020 2:42:03 PM

Redaction Log

Redaction Reasons by Exemption

Reason	Description	Pages (Count)
17 Banking Info	RCW 42.56.230 (5): 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	7(1)
22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1(1) 9(1)