

## Medical Quality Assurance Commission Physician Application Worksheet

Name NICOLE ARANETA Date of Birth 10/30/1983

Date Received 5/24/16 Temp Issued  Number  Closed

WSP Check  Fee  Photo  Data 1 15  AIDS  Attes  SSN  EBHAR

**Chronology**

Complete

**MISSING**

to \_\_\_\_\_  
to \_\_\_\_\_  
to \_\_\_\_\_

5/25/16  
FSMB

5/25/16  
AMA

ECFMG

FBI REPORT

**Personal Data "Yes"s**

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**Documentation Received**

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**Malpractice Cases**

1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_  
4 \_\_\_\_\_  
5 \_\_\_\_\_  
6 \_\_\_\_\_  
7 \_\_\_\_\_

**Synopsis**

**Disposition**


**Medical School**

Name NORTHWESTERN Year of Degree Jun-14  5/25/16 Transcripts  Translations

Examination Type  National  FLEX  USMLE  State Exam  LMCC  5/19/16 Scores Received

**Post Graduate Training Programs**

Received	Training Programs
<input checked="" type="checkbox"/> 5/22	TACOMA FAMILY RES 6/2014 PRES

**Post Graduate Training Programs**

Received	Training Programs

**Received State**

\_\_\_\_\_  
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**Received Hospital verification**

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**Received Hospital verification**

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Approved

*[Signature]*  
Signature

6/23/16  
Date

Comments:

\_\_\_\_\_

5.23.14

Washington State Department of ~~\$491-~~  
Health  
ST 009196  
REVENUE SECTION

43387

PHYSICIAN & SURGEON

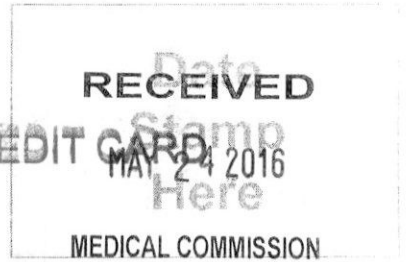
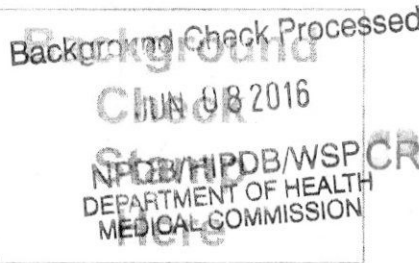
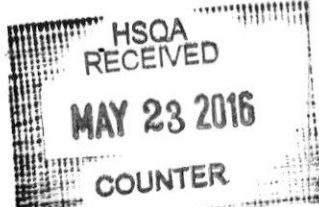
PRINT NAME Nicole Marie Rose S. Araneta

RETURN THIS PORTION  
WITH CHECK & APPLICATION

MD APP  
IF 0252090000 00236

\$491.00

2083-5/24/2016 11:35:17 AM-661



Revenue 0252090000

### Medical Practice License Application for MDs only

- National Boards
- Other State Exam
- LMCC (Must have been obtained after 1969)
- Flex Examination
- USMLE Examination

Select if the following applies:  Spouse or Registered Domestic Partner of Military Personnel

#### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions) 22 Licensee SSN	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number) 1558775908	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
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<b>Name</b>	First	Middle	Last
	Nicole Marie Rose	S.	Araneta

<b>Birth date (mm/dd/yyyy)</b> 10/30/1983	<b>Place of birth</b>		
	City	State	Country
	San Juan, Metro Manila		Philippines

<b>Address</b> Tacoma Family medicine Residency Program			
521 Martin Luther King Jr. way			

<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>County</b>
Tacoma	WA	98405	Pierce

<b>Country</b>
U.S.

<b>Phone (enter 10 digit #)</b> 253-403-2938	<b>Fax (enter 10 digit #)</b> 253-403-2908	<b>Cell (enter 10 digit #)</b> 23 LicenseeAddress
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**Email address:** Naraneta@multicare.org

**Mailing address if different from above address of record**

<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>County</b>
-------------	--------------	-----------------	---------------

**Country**

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

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

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

<b>Medical Speciality</b>	
<b>Medical school</b> Northwestern University - Feinberg School of Medicine	<b>Year of Graduation</b> 2014
<b>Medical Specialty</b> Family Medicine	

ML 60518898 16947686

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
- 1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

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

**"Currently"** means within the past two years.

**"Chemical substances"** include alcohol, drugs, or medications, whether taken legally or illegally.

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

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

**"Currently"** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

**2. Personal Data Questions (Cont.)**

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs? .....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? .....
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? .....
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application? .....
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? .....
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? .....

### 3. Medical Education and Postgraduate Training

Provide a date listing of your educational preparation and postgraduate training. If you need more space, attach a piece of paper.

Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Diploma or degree obtained (Quote titles in original language and translate to English.)	Number of years attended	Dates granted	
			Start mm/yyyy	End mm/yyyy
Medical education (list all medical schools attended) Northwestern University - Feinberg School of Medicine	MD	4	8/2009	5/2014
Postgraduate training (list all programs attended) Tacoma Family Medicine Residency			7/2014	-

### 4. Professional Experience

In date order list all professional experience received since graduation from medical school to the present. Exclude activities listed under other sections, identify any periods of time break of 30 days or more. If you need more space, attach a piece of paper.

Name and location of institution	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Nature of experience or specialty
N/A			

### 5. Hospital Privileges (Excluding postgraduate training hospital privileges)

Excluding postgraduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

Name of hospital	Dates attended	
	Start date mm/dd/yyyy	End date mm/dd/yyyy
N/A		

## 6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. Please provide verification directly from the state(s) that you have listed in this section.

State	Date license issued	License Number	Status of license	Any limitations on license
WA	11/13/14	ML60518898	active	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> No <input type="checkbox"/> Yes

## 7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four hours of education in the prevention, transmission, and treatment of AIDS. This education included topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

Applicant's initials na	Date 5/17/2016
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## 8. Applicant's Photograph

Photo Here



Height 5'5"

Weight 160-lbs.

Hair color Brown

Color of eyes Brown

Signature Nicole S. Aranda

Date of Photo 5/16/2016



## 9 Applicant's Attestation

I, Nicole M. Aruneta, declare under penalty of perjury under the  
(Print applicant name clearly)

laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated 05/17/2016 at Tacoma, WA  
(mm/dd/yyyy) (City, state)

By: Nicole S. Aruneta  
(Signature of applicant)

**Northwestern University, Feinberg School of Medicine Transcript**

Friday, May 20, 2016

**Student:** Araneta, Nicole Marl  
**Degree:** MD 5/22/2014 ✓  
**USMLE1:** 6/22/2011 P  
**USMLE2 CK:** 8/2/2012 P  
**USMLE2 CS:** 7/2/2012 P

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MAY 25 2016

DEPARTMENT OF HEALTH  
MEDICAL COMMISSION

**M1 2009-10 Academic Year**                      **Grade**  
 Problem Based Learning I                      P  
 Medical Decision Making I                      P  
 Medical Decision Making II                      P  
 Structure-Function                                  P  
 Patient, Physician & Society I                      P

**M2 2010-2011 Academic Year**                      **Grade**  
 Problem Based Learning II                      P  
 Scientific Basis of Medicine                      P  
 Medical Decision Making III                      P  
 Patient, Physician & Society II                      P

**M3 2011-2012 Academic Year**    **# Weeks**    **Grade**  
 Intro to Clinical Clerkships                      1.0    P  
 Surgery    12.0    P  
 Medicine    12.0    P  
 Psychiatry    4.0    P  
 Primary Care    4.0    HP  
 Neurology    4.0    P  
 Pediatrics    6.0    P  
 Interdisciplinary Medicine II                      2.4    P  
 Obstetrics & Gynecology                      6.0    P

**M4 2013-2014 Academic Year**    **# Weeks**    **Grade**  
 Medicine Subinternship                      4.0    HP  
 Family Medicine    4.0    H  
 Physical Med & Rehabilitation                      2.0    HP  
 Family Medicine    4.0    H  
 Adv Gross Anatomical Studies                      4.0    P  
 Intensive Care    4.0    P  
 Emergency Medicine                                  4.0    P  
 Clinical Dermatology                                  4.0    H  
 Patient, Physician & Society IV                      0.5    P  
 Teaching Selective    0.5    C

H - Honors (M3/M4 only)

HP - High Pass (Required M3/M4 only)

P - Pass

P^ - Pass after Remediation

P\* - Pass Repeated Course

F - Fail


W - Withdraw

I - Incomplete

R - Registered

C - Credit

This transcript is official only with signature and raised seal.

  
 Miroslava Rachuy  
 Academic Records Assistant 3  
 Registration and Records

\*\*\*05-21-2016 AURORA IL 605\*\*



Northwestern University  
Feinberg School of Medicine

Registration and Records  
Augusta Webster, MD,  
Office of Medical Education  
303 E. Chicago Avenue  
Ward 1-003  
Chicago, Illinois 60611-3008



U.S. POSTAGE PITNEY BOWES



ZIP 60611 \$ 000.39<sup>9</sup>  
02 4W  
0000335796 MAY 20 2016



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

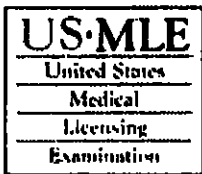
CWT-SAB 98504





NORTHWESTERN  
UNIVERSITY





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

This document was prepared by the  
Federation of State Medical Boards of the United States, Inc.  
Federation Place, 400 Fuller Wisser Road, Suite 300, Eules, TX 79039-3956 --Telephone (817)868-4000

Recipient:

Date: 05/19/2016

WASHINGTON MEDICAL QUALITY ASSURANCE COMMISSION

Examinee: Araneta, Nicole Marie Rose Sibug

Examinee ID: 52673910

Alt Name(s):

Date of Birth: 10/30/1983

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

### USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
6/22/2011	Pass	213	(188)	

### USMLE STEP 2

#### Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
8/2/2012	Pass	225	(196)	

#### Clinical Skills (CS)\*

Test Date	Pass/Fail	Total	MP	Comments
7/2/2012	Pass			

### USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
3/22/2016	Pass	225	(196)	

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

RECEIVED

MAY 23 2016

DEPARTMENT OF HEALTH  
MEDICAL COMMISSION

**RECEIVED**

JUN 21 2016

DEPARTMENT OF HEALTH  
MEDICAL COMMISSION

**Postgraduate Training Program Director  
Verification and Evaluation of Training**

To be completed by the applicant:

Facility name Tacoma Family Medicine Residency Program

Address 521 Martin Luther King Jr. Way Tacoma, WA 98405

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 postgraduate 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. All questions must be answered.

Applicant Name (Print or type) <u>Nicole M. Aruneta</u>	Birth date (mm/dd/yyyy) <u>10/30/1983</u>
Signature of applicant	

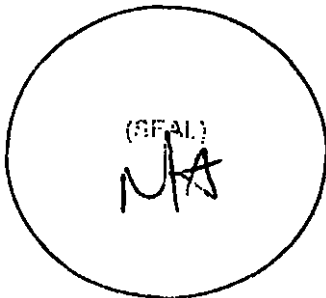
To be completed by the facility/agency/program:

1. Nicole M. Aruneta  or was engaged in postgraduate training in our program Tacoma Family Medicine Residency Program <sup>anticipated</sup> from Beginning date (month/year) 7/2014 to Ending date (month/year) 6/2017 in the field of Family Medicine

2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada?  Yes  No  
If no, does this program qualify the applicant to become board certified?  Yes  No

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

4. Did this applicant successfully complete this training program?  Yes  No pending  
 in process OR  expected date of completion 06/30/2017



Signature Kerry Watkins  
 Title Program Director  
 Email Kerry.Watrin@multicare.org  
 Address 521 MLK Jr. Way  
Tacoma, WA 98405  
 Date 6/21/16 Phone 253-403-2938

Return to address listed above



# AMA Physician Profile

PREPARED FOR

Washington State Dpt of Hlth, Tumwater, WA

**Name and Mailing Address**

NICOLE MARIE ROSE SIBUG ARANETA  
TACOMA FAMILY MEDICINE RESIDENCY  
521 MARTIN LUTHER KING JR WAY  
TACOMA, WA 98405-4238

**Primary Office Address**

SAME AS MAILING ADDRESS

**Phone** UNKNOWN

**Birth date** 10/30/1983

**Physician's major professional activity**

HOSPITAL BASED RESIDENTS - ALL YEARS

**Self-designated practice specialty**

FAMILY MEDICINE (primary)  
UNSPECIFIED (secondary)

*Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.*

**AMA membership status** NON MEMBER

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

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**Current and/or historical NPI information**

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1558775908	06/13/2014	NOT RPTD	NOT RPTD	NOT RPTD	04/23/2016

**Current and/or historical medical school**

NORTHWESTERN UNIVERSITY

**Degree Awarded:** YES  
**Degree Year:** 2014



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

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

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

*If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.*

**Sponsoring Institution:** MULTICARE MEDICAL CENTER  
**Sponsoring State:** WASHINGTON  
**Program name:** MULTICARE MEDICAL CENTER PROGRAM ✓  
**Specialty:** FAMILY MEDICINE  
**Dates:** 7/2014 - 6/2017 (Verified)

**Specialty Board Certification**

*Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:*

*The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.*

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





Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
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*For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (\*\*) Indicates an expired certificate.*

*This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties (ABMS). Copyright 2014 American Board of Medical Specialties. All right reserved.*

**Current and/or historical medical licensure**

Jurisdiction	MD / DO	Date Granted	Expiration Date	Status	License Type	Last Reported
Washington	MD	11/13/2014	07/31/2016	ACTIVE	LIMITED	05/02/2016 ✓

**Action Notifications**

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

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

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice.

**U.S. Drug Enforcement Administration (DEA)**

DEA number	Schedule	Expiration Date	Last Reported Date	Address
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None Reported

*Only the last three characters of active DEA numbers are displayed*

*Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.*

**ECFMG Certification**

Applicant Number:



*The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at <https://cvsonline2.ecfm.org/>*

## **Profile Information**

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

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

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

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**PRACTITIONER PROFILE**

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Prepared for: Washington Medical Quality Assurance Commission As of Date: 5/25/2016

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**PRACTITIONER INFORMATION**

Name: Nicole Marie Rose Sibug Araneta  
DOB: 10/30/1983  
Medical School: Northwestern University Medical School  
Chicago, Illinois, UNITED STATES  
Year of Grad: 2014  
Degree Type: MD

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**BOARD ACTIONS**

To date, there have been no actions reported to the FSMB

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**LICENSE HISTORY**

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
WASHINGTON	ML60518898	11/13/2014	7/31/2016	5/2/2016 ✓

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**PRACTITIONER PROFILE**

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Prepared for: Washington Medical Quality Assurance Commission As of Date:5/25/2016

Practitioner Name: Nicole Marie Rose Sibug Araneta

**ABMS® CERTIFICATION HISTORY**

No ABMS Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.

Northwestern University, Feinberg School of Medicine

Transcript

Wednesday, October 15, 2014

RECEIVED

Student: Araneta, Nicole Mari  
 Degree: MD 5/22/2014  
 USMLE1: 6/22/2011 P  
 USMLE2 CK: 8/2/2012 P  
 USMLE2 CS: 7/2/2012 P

OCT 20 2014

DEPARTMENT OF HEALTH  
 MEDICAL COMMISSION

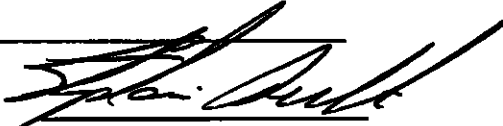
M1	2009-10 Academic Year		Grade
	Problem Based Learning I		P
	Medical Decision Making I		P
	Medical Decision Making II		P
	Structure-Function		P
	Patient, Physician & Society I		P
M2	2010-2011 Academic Year		Grade
	Problem Based Learning II		P
	Scientific Basis of Medicine		P
	Medical Decision Making III		P
	Patient, Physician & Society II		P
M3	2011-2012 Academic Year	# Weeks	Grade
	Intro to Clinical Clerkships	1.0	P
	Surgery	12.0	P
	Interdisciplinary Medicine III	2.4	P
	Medicine	12.0	P
	Psychiatry	4.0	P
	Primary Care	4.0	HP
	Neurology	4.0	P
	Pediatrics	6.0	P
	Obstetrics & Gynecology	6.0	P
M4	2013-2014 Academic Year	# Weeks	Grade
	Medicine Subinternship	4.0	HP
	Patient, Physician & Society IV	0.5	P
	Teaching Selective	0.5	C
	Family Medicine	4.0	H
	Physical Med & Rehabilitation	2.0	HP
	Family Medicine	4.0	H
	Adv Gross Anatomical Studies	4.0	P
	Intensive Care	4.0	P
	Emergency Medicine	4.0	P
	Clinical Dermatology	4.0	H

H - Honors (M3/M4 only)  
 HP - High Pass (Required M3/M4 only)  
 P - Pass  
 P^ - Pass after Remediation

P\* - Pass Repeated Course  
 F - Fail  
 W - Withdraw

I - Incomplete  
 R - Registered  
 C - Credit

This transcript is official only with signature and raised seal.



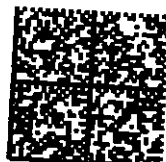
Stephanie Miller  
 Medical School Registrar  
 Registration and Records


NORTHWESTERN UNIVERSITY  
**FEINBERG**  
SCHOOL OF MEDICINE

Northwestern University  
Feinberg School of Medicine

Registration and Records  
Augusta Webster, MD,  
Office of Medical Education  
303 E. Chicago Avenue  
Ward 1-003  
Chicago, Illinois 60611-3008

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

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OCT 20 2014

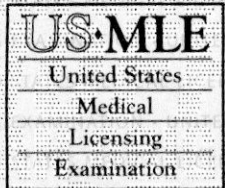
DEPARTMENT OF HEALTH  
MEDICAL COMMISSION

985047866





NORTHWESTERN  
UNIVERSITY



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

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

RECEIVED

MAY 26 2016

DEPARTMENT OF HEALTH  
MEDICAL COMMISSION

Recipient:

DEPARTMENT OF HEALTH  
MEDICAL QUALITY ASSURANCE COMMISSION  
P.O. BOX 47866  
OLYMPIA, WA 98504

Date: 05/19/2016

Examinee: Araneta, Nicole Marie Rose Sibug

Examinee ID: 52673910

Alt Name(s):

Date of Birth: 10/30/1983

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

### USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
6/22/2011	Pass	213	(188)	

### USMLE STEP 2

#### Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
8/2/2012	Pass	225	(196)	

#### Clinical Skills (CS)\*

Test Date	Pass/Fail	Total	MP	Comments
7/2/2012	Pass			

### USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
3/22/2016	Pass	225	(196)	

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





### Authenticity of USMLE Transcripts

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

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

### INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

#### STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

#### ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

**Indeterminate** - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. **No score is reported.** Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

**Irregular Behavior** - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

**Score Not Available** - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

#### ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

#### PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center 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 Data Center, 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 Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

2/2016

**Nimon, Lori (DOH)**

---

**From:** Nimon, Lori (DOH)  
**Sent:** Friday, June 17, 2016 11:47 AM  
**To:** 'nicki.araneta@gmail.com'  
**Subject:** Pending MD License 60666833

June 17, 2016

Dear Dr. Araneta,

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

**MISSING ITEMS**

**Need Post Grad verification from Tacoma Family 6/2014-present .**

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

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

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

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

Lori Nimon  
Health Services Consultant 1  
Medical Quality Assurance Commission  
PO Box 47866  
Olympia, WA. 98504  
[lori.nimon@doh.wa.gov](mailto:lori.nimon@doh.wa.gov)  
(360) 236-2765 📞  
(360) 236-2795 📠

***"Promoting Patient Safety and Enhancing the Integrity of the Profession through licensing, discipline, rule-making, and education."***

## Medical Quality Assurance Commission Limited License Application Worksheet

Name NICOLE ARANETA Date of Birth 10/30/1983

Date Received 10/23/14 # \_\_\_\_\_

WSP Check  Fee  Photo  Data1-13  AIDS  Attest  SSN  SS# letter

<p><b>Chronology</b></p> <div style="border: 1px solid black; width: 50px; height: 30px; margin: 5px;"></div> <p>Complete</p>	<p><b>Missing:</b></p> <p>_____ to _____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Residency <input type="checkbox"/> Institution</p> <p><input type="checkbox"/> Fellowship <input type="checkbox"/> City/County</p> <p><input type="checkbox"/> Teaching/Research</p>	<p><div style="border: 1px solid black; padding: 2px; display: inline-block;">10/27/14</div> <b>FSMB</b></p> <p><div style="border: 1px solid black; padding: 2px; display: inline-block;">10/27/14</div> <b>AMA</b></p>
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Personal Data "Yes"s	Documentation Received	Malpractice Cases	Synopsis	Disposition
_____	_____	1 _____		
_____	_____	2 _____		
_____	_____	3 _____		
_____	_____	4 _____		

### Medical School

Name NW UNIVERSITY Year of Degree Jun-14  Transcripts  Translations

**Post Graduate Training Programs**

Received	Training Programs

**Post Graduate Training Programs**

Received	Training Programs

**State Licensure**

Received	State Licensure

**Hospital Privileges**

Received	Hospital Privileges

Received  Program/Employment Verification  
**MULTICARE TACOMA- 7/1/14 ✓**

Approved *Dan Simpson* Signature Date 11/13/14

Comments: \_\_\_\_\_



Washington State Department of

Health

391-

LIMITED PHYSICIAN

REVENUE SECTION

PRINT NAME

Araneta, Nicole

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|| 0444 ||

\$391.00

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Background Check Processed  
 OCT 29 2014  
 WSP  
 DEPARTMENT OF HEALTH  
 MEDICAL COMMISSION

Date  
**RECEIVED**  
 OCT 28 2014  
 DEPARTMENT OF HEALTH  
 MEDICAL COMMISSION

Revenue 0252140000

## Limited Physician & Surgeons License Application

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

### 1. Demographic Information

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

22 Licensee SSN

- Male  
 Female

Name	First Nicole Marie Rose	Middle S.	Last ARANETA
Birth date (MM/DD/YYYY)	10/30/1983	City San Juan, Metro Manila	Place of Birth State Country Philippines
Address	Tacoma Family Medicine 521 Martin Luther King Jr Way		City Tacoma
State	WA	Zip Code 98405	County Pierce
Phone Number	253-403-2938	Fax Number	253-403-2968
Cell Number	23 LicenseeAddress		
Email Address:	NICKI.ARANETA@gmail.com		

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

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

### Institution or Training Program Information (Required)

Institution/Program Name	Multicare Tacoma Family Medicine Residency Program		
Institution/Program Mailing Address	521 Martin Luther King Jr Way		
City	Tacoma	State	WA
Zip	98405	County	Pierce

### Medical Specialty

Medical school	Northwestern University - The Feinberg School of Medicine	Year of Graduation	2014
Medical Specialty	Family Medicine		

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
- 1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

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

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....
4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

**2. Personal Data Questions (Cont.)**

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction .....

**Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.**

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? .....

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs? .....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .....

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....

11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? .....

12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine? .....

13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application? .....

14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action? .....

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



### 3. Medical Education and Experience

Provide a chronological listing of your educational preparation and post-graduate training. If you need more space, attach a piece of paper.

Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Diploma or degree obtained (Quote titles in original language and translate to English.)	Number of years attended	Dates granted	
			Start (mm/yyyy)	End (mm/yyyy)
Medical education (list all medical schools attended) NORTHWESTERN UNIVERSITY - THE FEINBERG SCHOOL OF MEDICINE CHICAGO, IL	MD	4	08/2009	05/2014
Post graduate training (list all programs attended)				
TACOMA FAMILY MEDICINE RESIDENCY TACOMA, WA 98405			07/2014	—

### 4. Professional Experience

In chronological order list all professional experience received since graduation from medical school to the present. Exclude activities listed under other sections, identify any periods of time break of 30 days or more. If you need more space, attach a piece of paper.

Name and location of institution	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Nature of experience or specialty
N/A			

### 5. Hospital Privileges (Excluding post-graduate training hospital privileges.)

Excluding post-graduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

Name of hospital	Dates attended	
	Start date mm/dd/yyyy	End date mm/dd/yyyy
N/A		

## 6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. List in chronological order, starting with the most current.

State	Date license issued	License Number	Basis of License		Status of license	Any limitations on license
			Exam date passed	Endorsement		
NONE						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes

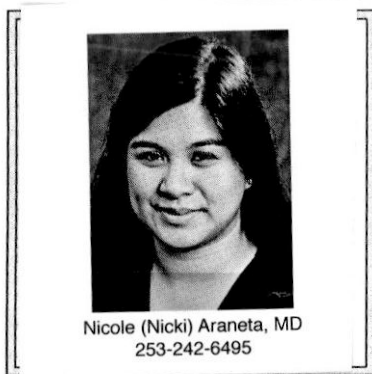
## 7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four hours of education in the prevention, transmission, and treatment of AIDS. This education included topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

Applicant's initials	Date
na	10/2/2014

## 8. Applicant's Photograph

Photo Here



Height 5'5"  
 Weight 175 lbs  
 Hair color DARK BROWN  
 Color of eyes BROWN

Signature NSAraneta

Date of Photo 06/16/2014

## 9. Applicant's Attestation

I, NICOLE M. ARANETA, declare under penalty of perjury under the  
(Print applicant name clearly)

laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated 10/2/2014 at Tacoma, WA (city, state)

By: N. Araneta  
Signature of applicant



**LMT**

**RECEIVED**

NOV 13 2014

DEPARTMENT OF HEALTH  
MEDICAL COMMISSION  
Medical Quality Assurance Commission

**Resident Physician Limited License**

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

Name of Resident Physician\*: NICOLE M. ARANETA, MD

Name of training program/specialty: MULTICARE TACOMA FAMILY MEDICINE RESIDENCY

Name of sponsoring institution: MULTICARE HEALTH SYSTEM

Beginning date 07/01/2014  
mm/dd/yyyy

[Signature]  
(Signature) Director of Program

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

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

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

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

10/19/14 Mailed



# AMA Physician Profile

**Name and Mailing Address**

N S ARANETA MD  
 TACOMA FAMILY MEDICINE RESIDENCY  
 521 MARTIN LUTHER KING JR WAY  
 TACOMA WA 98405-4238

**Primary Office Address**

SAME AS MAILING ADDRESS

Phone UNKNOWN

Birth date 10/30/1983

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

Self-designated practice specialty UNSPECIFIED (primary)

*Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership status NON MEMBER

---

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

---

**Current and/or historical NPI information**

National Provider Identifier (NPI)	Enumeration date	Deactivation date	Reactivation date	Replacement number	Last reported date
None	Reported				

**Current and/or historical medical school**

THE FEINBERG SCH OF MED, NORTHWESTERN UNIV, CHICAGO, IL 60611

Degree Awarded: Yes  
 Degree Year: 2014



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

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

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

**Sponsoring Institution:** MULTICARE MED CTR  
**Sponsoring State:** WASHINGTON  
**Program name:** MULTICARE MEDICAL CENTER PROGRAM ✓  
**Specialty:** FAMILY MEDICINE  
**Dates:** 07/2014 - 06/2017 (Verified)

*If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.*

**Current and/or historical medical licensure**

Jurisdiction	MD/ DO	Date granted	Expiration date	Status	License type	Last reported
--------------	-----------	-----------------	--------------------	--------	-----------------	------------------

NONE REPORTED TO DATE

**ECFMG Certification**

**Applicant Number:**

*The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at <https://cvsonline2.ecfm.org/>*



**U.S. Drug Enforcement Administration (DEA)**

DEA number	Schedule	Expiration date	Last Reported date	Address:
None	Reported			

*Only the last three characters of active DEA numbers are displayed*

*Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.*

**Specialty Board Certification**

*Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:*

*The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.*



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

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
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*For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (\*\*) Indicates an expired certificate.*

*This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties (ABMS). Copyright 2014 American Board of Medical Specialties. All right reserved.*

**Action notifications**

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

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

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Public Health Service.





**Additional Information**

To date, there is no additional information for this physician on file.

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

If any of the data in this Profile is believed to be incorrect, please log onto our website ([www.ama-assn.org/go/amaprofiles](http://www.ama-assn.org/go/amaprofiles)) and go to the order detail page. Select the 'D' following the physician's name and enter the data in questions. Or you can mark the issues on a copy of the profile and mail or fax to:

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

Fax: (312) 464-5900

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

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**PRACTITIONER PROFILE**

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Prepared for: Washington Medical Quality Assurance Commission As of Date:10/27/2014

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**PRACTITIONER INFORMATION**

Name: Nicole Marie Rose Sibug Araneta  
DOB: 10/30/1983  
Medical School: Northwestern University Medical School  
Chicago, Illinois, UNITED STATES  
Year of Grad: 2014  
Degree Type: MD

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**BOARD ACTIONS**

To date, there have been no actions reported to the FSMB

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**LICENSE HISTORY**

Jurisdiction	License Number	Issue Date	Expiration Date	Last Reported
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PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.

Professional Liability Action History

Applicant's name: NICOLE M. ARANETA Today's date: 10/2/2014

Please submit a form for each past or current professional liability claim or lawsuit which has been filed against you. Photocopy this page as needed. Only a legible and signed narrative which addresses all of the following details will be accepted.

- 1. Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. Please submit additional pages of narrative if necessary.

NONE

Date of occurrence: Details:

- 2. Date suit or claim was filed:

Name and address of insurance carrier that handled the claim:

- 3. Your status in the legal action (primary defendant, codefendant, other):
4. Current status of suit or other action:
5. Date of settlement, judgment, or dismissal:
6. If the case was settled out of court, or with a judgment, settlement amount paid on your behalf, please disclose the amount.

You must enclose a copy of final disposition of case this includes dismissals. \$

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature NS Araneta Date 10/2/2014

1/62 ...

100912. Araneta, N

\$391.00

13 me 10-17-14

**Nimon, Lori (DOH)**

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**From:** Nimon, Lori (DOH)  
**Sent:** Tuesday, November 04, 2014 11:54 AM  
**To:** 'nicki.araneta@gmail.com'  
**Subject:** Pending Residency License 60518898

**November 04, 2014**

**Dear Dr. Araneta,**

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

**Your application and fee of \$391.00 was received no October 23, 2014.**

**MISSING ITEMS**

**Transcripts with Degree Posted  
Residency Cert Form**

**If you have any further questions or need additional information, please feel free to call me at 360-236-2765 or email me at [lori.nimon@doh.wa.gov](mailto:lori.nimon@doh.wa.gov) or write to me at Department of Health Medical Quality Assurance Commission, PO Box 47866, Olympia, WA. 98504-7866.**

**Sincerely,**

**Lori Nimon  
HSC 1  
PO Box 47866  
Olympia, WA. 98504-7866  
(360) 236-2795 (F)**

**Nimon, Lori (DOH)**

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**From:** Nimon, Lori (DOH)  
**Sent:** Thursday, November 13, 2014 11:48 AM  
**To:** 'Nicole Araneta'  
**Subject:** RE: Pending Residency License 60518898  
**Attachments:** Resident Cert.pdf

Hi Nicole,

Thanks for checking in with me! The only item needed to complete your file is the attached Residency Cert form. Have your program manager complete it and then can fax or PDF back to me.

If I receive it today I will give your file to our licensing manager for review. ☺

Lori

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**From:** Nicole Araneta [<mailto:nicki.araneta@gmail.com>]  
**Sent:** Thursday, November 13, 2014 11:23 AM  
**To:** Nimon, Lori (DOH)  
**Subject:** Re: Pending Residency License 60518898

Hi Lori,

I hope you're doing well! I wanted to quickly ask about the status of my WA license as it's currently still showing as "pending". My residency program is having a training session in a week (on Nov 20), and I need my license to attend. Is there any chance it will be finalized in time?

Warmly,  
Nicole

On 4 November 2014 12:47, Nimon, Lori (DOH) <[Lori.Nimon@doh.wa.gov](mailto:Lori.Nimon@doh.wa.gov)> wrote:

Hi Nicole,

We double checked our pending documents since you said they sent it mid Oct. I am so glad you mentioned that..it was mistakenly paper clipped to another document that was not yours. Good news is we do have it and now just need the Residency Cert form to complete your file.

Have a great rest of your day! ☺

Lori

## Redaction Log

Total Number of Redactions in Document: 4

### Redaction Reasons by Page

Page	Reason	Description	Occurrences
4	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
4	23 LicenseeAddress	RCW 42.56.350(2): Health professionals. (2) The current residential address and current residential telephone number of a health care provider governed under chapter 18.130 RCW maintained in the files of the department are exempt from disclosure under this chapter	1
30	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
30	23 LicenseeAddress	RCW 42.56.350(2): Health professionals. (2) The current residential address and current residential telephone number of a health care provider governed under chapter 18.130 RCW maintained in the files of the department are exempt from disclosure under this chapter	1

# Redaction Log

## Redaction Reasons by Exemption

Reason	Description	Pages (Count)
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	4(1) 30(1)
23 LicenseeAddress	RCW 42.56.350(2): Health professionals. (2) The current residential address and current residential telephone number of a health care provider governed under chapter 18.130 RCW maintained in the files of the department are exempt from disclosure under this chapter	4(1) 30(1)