ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS
and Centralized Credentials Verification Service

www.armedicalboard.org

X Medicine/Surgery ____ Osteopathic Medicine/Surgery ____ Education License

1. Name CHARLIE BROWNE Social Security # _____
(Legibly Print full Legal Name)

2. Name as listed on your Driver's License or Passport: BROWNE, CHARLIE

Driver's License State and Number _____

3. Address 2409 E. GALER ST., SEATTLE WA 98112.

4. Address you wish license to be mailed:

_____

5. Phone (Res.) _____ (Work) _____ (Fax) 206-985-9806 (email) _____

6. Male ☒ Female ☐ Birth Date _____ Birth Place BARBADOS Race: MIXED

If born outside of U.S., how long have you lived in U.S. 28 Years 2 Months. Are you a citizen of U.S. X yes ___ no
If yes, and foreign born, attach proof of citizenship. If no, indicate your status with U.S. Immigration *(Attach copy of Visa/Work Permit)*

7. ECFMG Certificate # N/A Date Issued N/A

8. Intended practice location in Arkansas LITTLE ROCK Give name and address of hospital, clinic, group or private:
LITTLE ROCK FAMILY PLANNING SERVICES, 4 OFFICE PARK DRIVE, LITTLE ROCK 72211

9. Specialty OB/GYN Subspecialty _____
Board Certified (Date) 12/2001 Board Certified (Date) _____
Recertification 10/29/2009 Recertification _____

10. Drug Enforcement Administration Number _____ State WA Expiration Date 7-31-2010
State Controlled Substance License Number N/A State N/A Expiration Date N/A
State Controlled Substance License Number N/A State N/A Expiration Date N/A
Submit a copy of your DEA Registration Card and State Controlled Substance License to this office

11. UPIN # _____ Medicaid Provider # _____ Medicare Provider # _____
Accept Medicaid Patients? X Yes ____ No Accept Medicare Patients? X Yes ____ No

12. Professional Liability Insurance (**CURRENT** Carrier Name) _____
Policy # _____ Date of Expiration _____ Amount of Coverage _____
Send enclosed form to your insurance carrier and have them return directly to this office.

13. Medical School. Date Graduate 5 Mo 31 Day 1995 Yr Degree M.D.

	Name of Institution	Address	Date from	Date to
1st Year	UCLA-DREW/UCLA MED PROGRAM	1621 EAST 120TH STREET, LOS ANGELES, CA	08/91	05/92
2nd Year	SAME AS ABOVE	SAME	06/92	05/93
3rd Year	SAME AS ABOVE	SAME	06/93	05/94
4th Year	SAME AS ABOVE	SAME	06/94	05/95

Have Verification of Medical Education Form and an official Transcript mailed directly to this office.

FOR USE OF SECRETARY ONLY

License No. E-6577
Name Charlie Browne, MD
Application for License through endorsement by
USMLE

Application received 5-24-10
Fees $550 Date 5-24-10
License issued 8/6/10
Application Declined _____
Fees returned _____ 20____

NOTE: Application must be legible and completed in INK or Typed

14. Post Graduate Training (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
UNIVERSITY OF WASHINGTON	PACIFIC ST., SEATTLE, WA	OB/GYN RESIDENCY	06/95-05/99	Y

15. Fellowships (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
VIRGINIA MASON MEDICAL CTR	1100 NINTH AVE, SEATTLE, WA	GYNECOLOGIC	07/99 - 06/2001	Y

16. Circle which licensing exam you have taken: (USMLE) **NBME FLEX NBOME COMLEX LMCC**

- or -

State Board Examination – State N/A **Year** N/A **(Taken prior to 1975 only)**

17. Have you taken the SPEX exam in the last five years? ____ Yes X No **If yes, have certified copies of scores mailed directly to this office.**

18. Military Service? ____ Yes X No If yes, which Branch? N/A

Dates of Service N/A **Attach copy of separation papers and have records sent from Military Personnel Records Center. (See Instruction Sheet and Verification form.)**

19. List all states/countries in which you have or have had a medical license. **Have verification of each license mailed directly to this office. Send enclosed verification of Licensure Form.** (Form may be copied if necessary.)

State/Country	License #	Date Issued	Active Y/N
WA	MD35431	09/02/97	Y

State/Country	License #	Date Issued	Active Y/N

20. Professional References/Recommendations: **Have three physician (M.D. or D.O.) reference/recommendation letters mailed from their offices directly to this office.** These cannot be current partners or related to you. They must have worked with you and directly observed your professional performance in the recent past. At least one of these references/ recommendations must have had organizational responsibility for supervising your performance (i.e. department chief, service chief or training program director).

Name	Address	Association
JENNIFER MELVILLE, MD	2514 8TH AVE WEST, SEATTLE, WA 98119	PROFESSIONAL COLLEAGUE
TOM TVEDTEN, MD	4 OFFICE PARK DRIVE, LITTLE ROCK, AR 72211	PROFESSIONAL COLLEAGUE
JEFFREY GRICE, MD	320 WESTLAKE AVE N, STE 100 SEATTLE WA 98109	PAST SERVICE CHIEF

21. Professional Activities

List in chronological order all your professional activities, institutional affiliations or places of employment since the start of Medical School. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. Exclude Residency and Fellowship. You may attach additional sheets after completing this section, if space is not sufficient. *Do not submit curriculum vitae (CV) in lieu of completing this section.*

From	To	Status	Location & Complete Address	Position
01/99	12/02	ACTIVE	SWEDISH FAMILY MEDICINE DYSPLASIA CLINIC 1401 MADISON, SUITE 100 SEATTLE, WA 98104-1338	ATTENDING PHYSICIAN
07/99	10/05	ACTIVE	HARBORVIEW MEDICAL CENTER 325 NINTH AVE SEATTLE, WA 98104	ASSOCIATE MEDICAL STAFF
07/99	10/05	ACTIVE	UNIVERSITY OF WASHINGTON MED CTR 1959 NE PACIFIC ST SEATTLE, WA 98195	ASSOCIATE MEDICAL STAFF
07/99	PRESENT	COURTESY	VIRGINIA MASON MEDICAL CENTER 1100 NINTH AVE, G1-MSO SEATTLE, WA 98101	MEDICAL STAFF
07/99	PRESENT	ACTIVE	GROUP HEALTH COOPERATIVE 310 15TH AVE E, CNB-2 SEATTLE, WA 98112	MEDICAL STAFF
07/99	12/00	ACTIVE	PLANNED PARENTHOOD OF THE GREAT NW 2001 EAST MADISON ST SEATTLE, WA 98122	STAFF PHYSICIAN
01/00	PRESENT	COURTESY	SWEDISH MEDICAL CENTER 747 BROADWAY SEATTLE, WA 98122-4307	MEDICAL STAFF
11/02	PRESENT	ACTIVE	ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE (AAAHC) 5250 OLD ORCHARD ROAD, SUITE 200 SKOKIE, IL 60077	SURVEYOR
10/07	PRESENT	ACTIVE	ALL WOMEN'S HEALTH NORTH 9730 3RD AVE NE, SUITE 200 SEATTLE, WA 98115	MEDICAL DIRECTOR
02/09	PRESENT	ACTIVE	PLANNED PARENTHOOD OF GREATER WASHINGTON AND NORTHERN IDAHO (PPGUNI) 1117 TIETON DR YAKIMA, WA 98902	STAFF PHYSICIAN

- Please review this list carefully. If there are gaps in your chronological history you are required to provide a brief explanation. **Send enclosed Verification Hospital/Clinic forms to each facility. (See Instruction Sheet)**
- **Complete all forms in black or blue ink ONLY.**

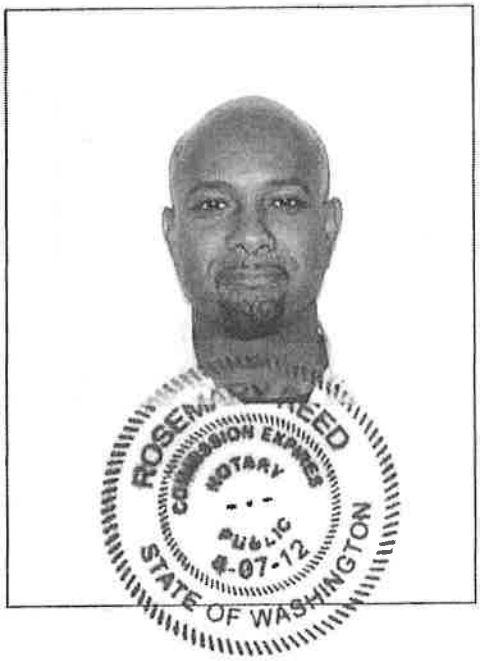
Attach explanation of any "yes" answers. Refer to Instruction Sheet for the following questions.	YES	NO
22. Have you ever failed any licensing exam, or any part of a licensing exam, which caused you to retake it? Which exam (USMLE, NBOME, etc.)?	___	X
23. Has your application for examination or licensure ever been rejected, denied or withdrawn?	___	X
24. Has any medical licensing board ever placed your license on probation, suspension or has it revoked a license or certificate it had granted you? If yes, list name and address of board.	___	X
25. Have you ever been ordered to appear before a state medical board for any reason other than licensure?	___	X
26. Have disciplinary procedures ever been initiated toward you by either a medical board or hospital? Explain.	___	X
27. Have your privileges at any hospital been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending?	___	X
28. Have you ever voluntarily surrendered your license in any state?	___	X
29. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.)	___	X
30. Have you ever been denied provider participation in any state or Federal Medicaid program?	___	X
31. Have you ever previously made application to the Arkansas State Medical Board?	___	X
32. Have you ever been warned, censured by, or requested to withdraw from, any hospital in which you have trained, been a staff member or held hospital privileges? If yes, explain.	___	X
33. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency or fellowship program? If yes, explain.	___	X
34. Have you ever, voluntarily or involuntarily, left a training institution program before completing it? If yes, explain.	___	X
35. Have you ever been reported to the National Practitioners Data Bank or subject to NPDB adverse action report?	___	X
36. Have you resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted?	___	X
37. Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending?	___	X
38. Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicaid programs? If yes, name state _____	___	X
40. Have you ever been cited by a peer review organization? Explain Give the name and address of the organization _____	___	X
41. Have you ever had to discontinue practice for any reason for a period longer than one month? If yes, explain.	___	X
42. Have you been, or are you presently, being treated for alcoholism, or substance abuse? If yes, was this voluntary or the result of a medical board action? Explain.	___	X
43. Do you currently, or have you had, any physical or mental health condition, including alcohol or drug dependency, which with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately?	___	X

	YES	NO
44. Have you ever had a DWI? How many? _____ Date(s) occurred _____	____	X
45. Have you ever been treated for drug or substance abuse outside a hospital setting? Explain.	____	X
46. Have you ever been treated for drug or substance abuse in a treatment center or hospital? Give name of institution, date and length of stay? _____	____	X
47. Are you currently being, or have you ever been, monitored by a Physician Health Committee in any state? If yes, give state(s) _____ Ask your treating physician to send documentation of your status.	____	X
48. Have you ever been rejected by a medical society?	____	X
49. Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? If yes, explain.	____	X
50. Have you ever defaulted on any Health Education Assistance Loan? If yes, explain.	____	X
51. To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? If yes, explain.	____	X

If, during the application process, you become aware of any such investigation, you are required to report it to this office.

AFFIDAVIT OF APPLICANT

I, CHARLIE BROWNE, certify after being sworn, that all of the information supplied in the foregoing application is true, correct, current and complete to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation or denial of any license to practice medicine granted to me, and criminal prosecution to the fullest extent of the law.



Applicant's Signature (In INK)

5-7-2010

Date Signed

Sworn to and subscribed before me this 7th day of May, 20 10.

My Commission Expires: 04-07-12

Signature of Notary Public

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

Douglas Smart

Rev. 5/2/06 ljm
Form cannot be copied.

Little Rock
Family Planning Services

4 Office Park Drive
Little Rock, Arkansas 72211
(501) 225-3836
Fax (501) 225-8705
Toll Free (800) 272-2183
www.lrfps.com

To: Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AR 72202

From: Thomas H. Tvedten, MD
4 Office Park Drive
Little Rock, AR 72211
(501) 225-3836 office

Re: Charlie Browne, MD

Seattle, WA 98112

Dear Sirs,

This letter is to verify the intended employment of Dr. Charlie Browne, by this clinic, from time to time as back up coverage to the current physicians.

Sincerely,

Thomas H. Tvedten M.D.

May 31, 2010

Charlie Browne, MD FACOG

Seattle, WA 98112

Arkansas State Medical Board
2100 Riverfront Drive,
Little Rock, Arkansas 72202

Dear Arkansas State Medical Board,

This is a response to your letter dated May 26, 2010 addressed to me. Regarding the list of items:

1. I called the Hospital and asked for the status on the fellowship verification letter. They told me that it was mailed via UPS on 5/12/10. The tracking number (1Z9864972210077251) shows that it was delivered 5/13/10 and signed for by "Welch" (printout enclosed). If it is missing however, I can ask the hospital to mail it again to your office. Please let me know.

2. I was told that Dr Tvedten's letter of recommendation was mailed on May 26, so you should be receiving it shortly.

3. I would like to offer a correction to question #22, which I initially incorrectly answered "no". This was simply a lapse in memory, having taken this part of the exam (USMLE Step 2) about sixteen years ago, I forgot that my initial attempt was a failing grade. As best my memory serves me now I believe I retook that part of the exam one year later and passed. Again as best my memory serves me, that is the only exam I can remember failing. You will find enclosed a corrected page 4 of the application that includes that question (#22). I apologize for this oversight.

5. I contacted the Washington State licensing board re: the certification verification and have been told that it will be mailed June 1, 2010.

6. AMA profile has been requested and you should be receiving it shortly.

7. I was told that the letter from my prospective employer in Arkansas, LRFPS, was mailed on May 26, so you should be receiving it shortly.

8. You will find enclosed my State and Federal Criminal Background Check Packet.

9. I was told that the verification from Swedish Family Medicine Dysplasia Clinic, was mailed on May 20, so you should be receiving it shortly.
   I was also told that the verification from the University of Washington was mailed along with the one from Harborview Medical Center, as both these programs are under the blanket of one administration. Therefore, you should be receiving this shortly as well.

Finally, To explain the two fellowships that you see on my CV that were not included on my application… the reasoning is that these were brief, non-professional, fellowships that I did as a student prior to my graduation from medical school. I consider them part of my overall medical studies. Furthermore, per the instruction packet, it instructs me to list professional activities "since graduation from medical school" so I did not think I needed to include these there as again, I did these activities prior to graduation. Please let me know if you need any further explanation.

Thank you very much. I very much appreciate your time and effort.

Sincerely,

Charlie Browne

Attach explanation of any "yes" answers. Refer to Instruction Sheet for the following questions.	YES	NO
22. Have you ever failed any licensing exam, or any part of a licensing exam, which caused you to retake it? Which exam (USMLE, NBOME, etc.)?	X Corrected 5/31/10	X
23. Has your application for examination or licensure ever been rejected, denied or withdrawn?		X
24. Has any medical licensing board ever placed your license on probation, suspension or has it revoked a license or certificate it had granted you? If yes, list name and address of board. _____		X
25. Have you ever been ordered to appear before a state medical board for any reason other than licensure?		X
26. Have disciplinary procedures ever been initiated toward you by either a medical board or hospital? Explain.		X
27. Have your privileges at any hospital been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending?		X
28. Have you ever voluntarily surrendered your license in any state?		X
29. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.)		X
30. Have you ever been denied provider participation in any state or Federal Medicaid program?		X
31. Have you ever previously made application to the Arkansas State Medical Board?		X
32. Have you ever been warned, censured by, or requested to withdraw from, any hospital in which you have trained, been a staff member or held hospital privileges? If yes, explain.		X
33. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency or fellowship program? If yes, explain.		X
34. Have you ever, voluntarily or involuntarily, left a training institution program before completing it? If yes, explain.		X
35. Have you ever been reported to the National Practitioners Data Bank or subject to NPDB adverse action report?		X
36. Have you resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted?		X
37. Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending?		X
38. Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicaid programs? If yes, name state _____		X
40. Have you ever been cited by a peer review organization? Explain Give the name and address of the organization _____		X
41. Have you ever had to discontinue practice for any reason for a period longer than one month? If yes, explain.		X
42. Have you been, or are you presently, being treated for alcoholism, or substance abuse? If yes, was this voluntary or the result of a medical board action? Explain.		X
43. Do you currently, or have you had, any physical or mental health condition, including alcohol or drug dependency, which with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately?		X

ABO+G

American Board of Obstetrics & Gynecology
[illegible]
Larry C. Gilstrap, III, M.D.
Executive Director

Alvin L. Brekken, M.D.
Assistant to the Executive Director

Kenneth L. Noller, M.D.
Director of Evaluation

The Vineyard Centre
2915 Vine Street
Dallas, TX 75204
Phone (214) 871-1619
Fax (214) 871-1943

May 20, 2010

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AE 72202-1435

Reference: **Charlie Browne, MD**
ABOG #9001440

Dear Administrator:

The above referenced physician is a **Diplomate** of the American Board of Obstetrics & Gynecology, Inc. (ABOG) certified in the 2001 examination certificate renewed through the *Annual Board Certification* from 2006 to 2007 and through the *Maintenance of Certification* process in 2008 & 2009 (expires 12/31/2010).

This office responds to inquiries concerning the status of physicians in the certification process according to the following:

1. An individual is a registered graduate with ABOG when, at the time of application, ABOG rules that he/she has fulfilled the requirements to take the written examination.

2. An individual achieves active candidate status by passing the written examination. This status is limited to six years (five years for subspecialty) or three attempts to pass the oral examination. If active status has expired, it may be regained by repeating and passing ABOG's written examination.

3. An individual becomes a **Diplomate** of ABOG when he/she has fulfilled all requirements, has satisfactorily completed the written and oral examinations and has been awarded ABOG's certifying diploma. Diplomas issued prior to 1986 for basic Ob/Gyn and November 1987 for subspecialties are unlimited. Diplomas issued in 1986 for basic Ob/Gyn and November 1987 for subspecialties, as well as all subsequent dates, are valid for a maximum of 10 years. The expiration date on a subspecialty diploma is the same as that of the Ob/Gyn diploma.

Sincerely yours,

Larry C. Gilstrap III, MD

Larry C. Gilstrap, M.D.
Executive Director

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF MEDICAL EDUCATION

DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA
Name of Institution

12-159 CHS, BOX 951720
Street

LOS ANGELES CA 90095-1720
City State Zip

I, CHARLIE BROWNE, M.D./D.O., have applied for a license to practice medicine in the state
(Print full name)
of Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my **Medical Education.**

I hereby authorize UCLA, its staff, or representative to provide the Arkansas State Medical
(Name of medical / osteopathic school or college)
Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand completed forms returned to me wil not be accepted for verification purposes.

Sincerely, _____ Date or Birth MO DAY YR
(Signature of Applicant)

Social Security Number ___ - Date of Graduation 06 / 02 / 1995
MO DAY YR

For verification of MEDICAL EDUCATION ONLY Please provide exact date.

The following section must be completed by the dean or registrar of the medical or osteopathic school and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted.** *Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.*

This certifies that Charlie Mark Anthony Browne
(Full name of applicant)

Enrolled in UCLA School of Medicine
(Name of medical or osteopathic school)

on 08 / 12 / 1991 graduated 06 / 02 / 1995 with a degree in Medicine (M.D.)
MO DAY YR MO DAY YR

Further, the records of this institution indicate that the attached photograph
(Check one) ☒ Represents a true likeness of the above named applicant.
☐ Does not represent a true likeness of the above named applicant.

AN OFFICIAL SCHOOL TRANSCRIPT MUST BE RETURNED WITH THIS FORM

By Martin Hunter
Signature of the dean or registrar **(NO STAMPED SIGNATURES ACCEPTED)**

SEAL

Print or Type Name of dean/registrar Martin Hunter, Registrar

Signed and the college Seal affixed on 05 / 12 / 2010
MO DAY YR

Phone (310) 825-6282 Fax (310) 825-6262

Medical school seal MUST be imprinted partially on photograph.

Rev. 12/01amm Form may be copied.

UNIVERSITY OF CALIFORNIA, LOS ANGELES

UCLA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

OFFICE OF STUDENT AFFAIRS
DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA
CENTER FOR THE HEALTH SCIENCES
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90095-1720
PHONE (310) 825-6281
FAX: (310) 794-9574

www.medstudent.ucla.edu

June 30, 2010

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AR 72202-1435

RE: **Charlie Browne, M.D.**

To Whom It May Concern:

This letter is to verify that **Charlie Browne** graduated in good academic standing from the UCLA School of Medicine, now known as the David Geffen School of Medicine at UCLA. Dr. Browne was part of the Charles Drew University Program at UCLA. The Drew Program, who handled their own transcripts until 2005, conducts a separate ceremony for their graduates; thus, the date on his transcript (May 21, 1995) reflects his graduation from their program. His official graduation date from UCLA, however, is June 2, 1995.

If you have any questions, please do not hesitate to contact me in the Registrar's Office at mhunter@mednet.ucla.edu or at (310) 825-6282.

Sincerely,

Martin Hunter

Martin Hunter, M.S.
Registrar / Student Records Manager
Office of the Registrar-Student Affairs

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF POSTGRADUATE TRAINING

DAVID ESCHENBACH, M.D.
Name of Program Director

UNIVERSITY OF WASHINGTON - DEPT OF OB-GYN EDUCATION
Name of Institution

1959 NE PACIFIC ST - BOX 356460
Street

SEATTLE WA 98195
City State Zip

I, CHARLIE BROWNE (Print full name), have applied for a license to practice medicine in the State of Arkansas. As part of the application process, the Arkansas State Medical Board requires a reference from the program director of each ACGME accredited **Postgraduate Training** program to which I have been appointed.

I hereby authorize UWMC - DEPT OF OB/GYN (Name of Institution), its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and /or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____

Date of Birth MO ____ DAY ____ YR ____ Social Security Number: ___-__-____

For verification of POSTGRADUATE TRAINING Please provide exact date(s).

The following section must be completed by the Program Director or his/her representative and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted. DO NOT USE SIGNATURE STAMPS.**

This is to certify that Charlie Brown MD (Name of applicant), a graduate of University of Washington (Medical School)

commenced postgraduate training (*internship/residency/clinical fellowship) in Obstetrics + Gynecology Univ. (Legibly Print or Type Name and address of training program)

Washington, Box 356460, Seattle WA 98195-6460

on 06 / 25 / 95 (MO / DAY / YR) and completed **(check one)** ☒ successfully ☐ **unsuccessfully such training on 06 / 30 / 99 (MO / DAY / YR).

or anticipated graduation date on ____/____/____.

☐ Internship- Name of Dept./Dates _____

☒ Residency- Name of Dept./Dates Obstetrics + Gynecology

☐ Fellowship-Name of Dept./Dates _____ ☐ Clinical ☐ Research

Type or Legibly Print Name: Seine Chiang MD Signature: _____ (DO NOT USE SIGNATURE STAMPS)

Date Signed Program Director - Associate Professor

Title 5/7/2010

Tel. No. (206) 543 9626 Fax No. (206) 543 3915

COMMENTS: _____ (Attach additional sheet if needed.)

***List the reason for unsuccessful completion in Comments or attach a letter of explanation.*

*Circle one.

Rev. 12/11/07 LJM Form may be copied

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

GLASER FAMILY MEDICINE DYSPLASIA CLINIC
Name of Institution

Street SEATTLE WA 9
City State Zip

I, CHARLIE BROWNE, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)
the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize GLASER DYSPLASIA CLINIC its staff, or representative to provide the Arkansas Sate Medical Board
(Name of Hospital)
any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, [signature]

Date of Birth ___ / ___ / ___ (MO / DAY / YR) Social Security Number _____

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, KAREN NIEMAN state that the above named physician has/had the following staff privileges
(Print Full Name)
(Circle One): Courtesy (Active Staff) Temporary - Other _____, at our hospital/clinic from 01 / 01 / 99 (MO / DAY / YR) to 12 / 31 / 02 (MO / DAY / YR)

Indicate the scope of Clinical Privileges, if any: _____

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Karen Nierman
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Karen Nierman
Signature

RN
Title

5 / 14 / 10 Email address: Karen.nierman@swedish.org
Date Signed (MO/DAY/YR)

(206) 386-6161 (206) 215-6018
Telephone Number Fax Number

May 31, 2010

Charlie Browne, MD FACOG

Seattle, WA 98112

Arkansas State Medical Board
2100 Riverfront Drive,
Little Rock, Arkansas 72202

Dear Arkansas State Medical Board,

I would like to offer an explanation for interchangeably using the names Swedish Family Medicine Dysplasia Clinic and Glaser Family Medicine Dysplasia Clinic in my application. They are both and one the same. The clinic is known by both the Swedish Glaser Family Medicine Dysplasia Clinic, as well as the Glaser Family Medicine Dysplasia Clinic at Swedish (Hospital).

I apologize for this confusion.

Thank you very much.

Sincerely,

Charlie Browne

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive Little Rock, Arkansas 72202 (501) 296-1802

VERIFICATION OF POSTGRADUATE TRAINING

Name of Program Director: VIRGINIA MASON MEDICAL CENTER

Name of Institution: 1100 NINTH AVE - DEPT OF OB/GYN

Street: SEATTLE WA

City State Zip

I, CHARLIE BROWNE (Print full name) have applied for a license to practice medicine in the State of Arkansas. As part of the application process, the Arkansas State Medical Board requires a reference from the program director of each ACGME accredited Postgraduate Training program to which I have been appointed.

I hereby authorize VIRGINIA MASON MEDICAL CENTER (Name of Institution), its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and /or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that the completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, [signature]

Date of Birth: MO DAY YR Social Security Number: [redacted]

For verification of POSTGRADUATE TRAINING Please provide exact date(s).

The following section must be completed by the Program Director or his/her representative and returned directly to the Arkansas State Medical Board. Verifications returned to the applicant will not be accepted. DO NOT USE SIGNATURE STAMPS.

This is to certify that Charlie Browne, MD (Name of Applicant) graduated of UCLA (Medical School)

commenced postgraduate training (Internship/residency/practice fellowship) in GYN Pelvic Fellowship - Virginia Mason Medical Center

on 07 / 01 / 1999 (MO DAY YR) and completed (check one) ☒ successfully ☐ [illegible] such training on 06 / 30 / 2001 (MO DAY YR)

or anticipated graduation date on ____/____/____

☐ Internship- Name of Dept./Clinic: ____

☐ Residency- Name of Dept./Clinic: ____

☐ Fellowship-Name of Dept./Clinic: ____

☐ Clinical ☐ Research

Signature of Program Director: Evelyn Sinsel (Print Name) Signature: Evelyn Sinsel (DO NOT USE SIGNATURE STAMPS)

Date Signed: 5-10-2010

Title: Manager, Medical Staff Services

Tel No. 206.583-6430 Fax No. 206.625-7237

Comments: Dr. Browne is currently a member of the medical staff in good standing

*For the reason for unsuccessful completion in Comments or attach a letter of explanation.

Copies of this form may be copied

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

HARBORVIEW MEDICAL CENTER
Name of Institution

325 NINTH AVE
Street

SEATTLE WA 98104
City State Zip

I, CHARLIE BROWNE, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)

the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize HARBORVIEW MEDICAL CENTER, its staff, or representative to provide the Arkansas Sate Medical Board
(Name of Hospital)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, [signature]

Date of Birth ___ ___ ___ (MO DAY YR) Social Security Number ___ ___

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

Temporary Privilege: 07/01/1999-01/27/2000

I, Colleen McDonald, state that the above named physician has/had the following staff privileges
(Print Full Name)

(Circle One): Courtesy - Active Staff – Temporary - Other Associate at our hospital/clinic from 01 / 27 / 2000 to 10 / 01 / 2005
(MO DAY YR) (MO DAY YR)

Indicate the scope of Clinical Privileges, if any: OB/GYN, Core IN, Core out

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Colleen McDonald, CCS
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Colleen McDonald, CCS
Signature

Program Supervisor
Title

05 / 14 / 2010
Date Signed (MO DAY YR)

mcdonald@u.washington.edu
Email address

206 616 0890
Telephone Number

206, 616-5882
Fax Number

Rev 8/18/06 lm Form may be copied.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

UNIVERSITY OF WASHINGTON MEDICAL CENTER
Name of Institution
OFFICE OF MEDICAL STAFF APPOINTMENTS - 1325 FOURTH AVE, STE 2000
Street
SEATTLE WA 98101
City State Zip

I, CHARLIE BROWNE, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)
the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment

I hereby authorize UNIVERSITY OF WASHINGTON, its staff, or representative to provide the Arkansas Sate Medical Board
(Name of Hospital)
any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named Institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, [signature]

Date of Birth ___ ___ ___ Social Security Number ___
MO DAY YR

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Colleen Mcdonald Temporary Privileges: 01/01/1999 – 01/03/2000
(Print Full Name) state that the above-named physician has/had the following staff privileges

(Circle One): Courtesy - Active Staff –Temporary - Other Associate at our hospital/clinic from 01 (MO) 03 (DAY) 2000 to 10 (MO) 01 (DAY) 2005 (YR)

Indicate the scope of Clinical Privileges, if any: OB/GYN Care Treatment, Care attention

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Colleen Mcdonald, CPCS
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)
Colleen Mcdonald, CPCS
Signature
Program Supervisor
Title
05, 14, 2010
Date Signed (MO, DAY, YR)
mcdonald@u.washington.edu
Email address
206 685 0890
Telephone Number
206 616 5882
Fax Number

Rev 8/18/06 ljm Form may be copied.

UW Medicine
SCHOOL OF MEDICINE

Department of Obstetrics & Gynecology
Division of Education

Box 356460
Seattle, WA 98195-6460

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

UNIVERSITY OF WASHINGTON MEDICAL CENTER (UWMC)
Name of Institution

BOX 356460
Street

SEATTLE WA 98195
City State Zip

I, CHARLIE BROWNE, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)

the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize UWMC, its staff, or representative to provide the Arkansas Sate Medical Board
(Name of Hospital)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, [signature]

Date of Birth ___ / ___ / ___ Social Security Number ___
MO DAY YR

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, CHARLIE BROWNE state that the above named physician has/had the following staff privileges
(Print Full Name)

(Circle One): Courtesy - Active Staff – Temporary - (Other) TEACHING* at our hospital/clinic from 07 / 01 / 99 to PRESENT
MO DAY YR MO DAY YR

Indicate the scope of Clinical Privileges, if any: AUXILIARY/CLINICAL FACULTY (Teaching)

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☐ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily). NA* (As clinical Faculty * Dr Browne did not have Hosp. priv.)

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Elizabeth A Jarrett
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

EJarrett
Signature

Res. Program Manager
Title

06/03/2010 EJarrett@UW.Edu
Date Signed (MO/DAY/YR) Email address

(206) 543-3021 (206) 543-3915
Telephone Number Fax Number

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedlenboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

GROUP HEALTH COOPERATIVE
Name of Institution

P.O. BOX 34262
Street

TUKWILA WA 98124
City State Zip

I, CHARLIE BROWNE (Print Full Name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize GROUP HEALTH COOPERATIVE (Name of Hospital), its staff, or representative to provide the Arkansas Sate Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, [signature]

Date of Birth ___ (MO) ___ (DAY) ___ (YR) Social Security Number ___

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Nichole QUINN (Print Full Name) state that the above named physician has/had the following staff privileges

(Circle One): Courtesy - Active Staff - Temporary - (Other) LOCUMS, at our hospital/clinic from 07 (MO) 20 (DAY) 97 (YR) to ___ (MO) ___ (DAY) PRESENT (YR)

Indicate the scope of Clinical Privileges, if any: OB/GYN

During the stated period of time, the clinical privileges of this individual (check one) ☒ Were ☐ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

* NO LONGER WORKING at Group Health Central Hospital; NO Credentialing CONCERNS

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Nichole QUINN
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Nichole Quinn
Signature

Credentialing Supervisor
Title

05/11/10 Email address: QUINN.N@ghc.org
Date Signed (MO/DAY/YR)

(206) 988-3077 (206) 988-2074
Telephone Number Fax Number

Rev. 8/18/06 ljm Form may be copied.

GroupHealth

Group Health Cooperative
Credentialing Department
Nichole Quinn
Credentialing Supervisor
PO BOX 34262
Tukwila WA 98124
Phone: (206) 988-2077
Fax: (206) 988-2084
E-mail: ballard.n@ghc.org

June 01, 2010

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, Arkansas 72202

Regarding:	Charlie M Browne, MD
Integrated Health System::	Group Health Cooperative (GHC)
GHC Olympic Medical Center:	07/20/1999 - Present
GHC Central Hosptial:	07/20/1999 – 04/06/2010
Specialty:	Obstetrics And Gynecology

The above-named practitioner is in good standing at Group Health Cooperative in the specialty noted above. This individual's practice has been regularly reviewed as part of our ongoing quality assurance program.

To the best of our knowledge, there have been no disciplinary proceedings undertaken against this individual, nor have clinical privileges, if applicable, been denied, reduced, revoked, restricted, or suspended. In, April 2010, Central Hospital privileges were allowed to expire due to no hospital work. Currently works in clinic only

If you require insurance or claims history verification for a Associate, Active, Locum Tenens, or Employed status practitioner, please contact Group Health Cooperative, Risk Management by fax: 206-877-0625 (fax is preferred) or by mail at 320 Westlake Ave N, Suite 100 Seattle, WA 98109-5233.

Should further information be required, please contact the Credentialing Department at the number above.

Sincerely,

Nichole Quinn

Nichole Quinn
Group Health Cooperative
Credentialing Department

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 2[illegible]-1802

www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

PLANNED PARENTHOOD OF THE GREAT NORTHWEST
Name of Institution

2001 EAST MADISON STREET
Street

SEATTLE WA 98122
City State Zip

I, CHARLIE BROWNE (Print Full Name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize PLANNED PARENTHOOD (Name of Hospital), its staff, or representative to provide the Arkansas Sate Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, [signature]

Date of Birth ___ MO ___ DAY ___ YR Social Security Number _____

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. Form must be signed.

I, AMY ETELAMAKI (Print Full Name) state that the above named physician has/had the following staff privileges

(Circle One): Courtesy / Active Staff / Temporary - Other _____, at our hospital/clinic from 7/25/99 (MO/DAY/YR) to 11/17/06 (MO/DAY/YR)

Indicate the scope of Clinical Privileges, if any: _____

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

*Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.

AMY ETELAMAKI
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMP)

Amy Etelamaki
Signature

HR
Title

5, 14, 10
Date Signed (MO/DAY/YR)

amye@ppgnw.org
Email address:

206 328 6808
Telephone Number

206 953 3191
Fax Number

Rev. 8/18/06 jm Form may be copied.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

SWEDISH MEDICAL CENTER
Name of Institution

747 BROADWAY
Street

SEATTLE WA 98122-4307
City State Zip

CHARLIE BROWNE (M.D.D.) have applied for a license to practice medicine in the State of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic at which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize SWEDISH MEDICAL CENTER its staff or representatives to provide the Arkansas State Medical Board (Name of Hospital)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release them and all persons acting on behalf of the above named institution and/or person for any and all acts performed in furnishing the request, provided that such acts are performed in good faith and without malice. Further, I request that the completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board by you.

Signature

Date of Birth (MO) (DAY) (YR) Social Security Number

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. Form must be signed.

I Mary F. White (Print or Type Name) state that the above named physician has/has the following staff privileges

(Circle One) (Active) Active Staff – Temporary – Other at our hospital/clinic from 1/25/00 (MO/DAY/YR) to Present (MO/DAY/YR)

Indicate the scope of Clinical Privileges if any: OB/GYN

During the stated period of time, the clinical privileges of this individual (check one): ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or operation of law) voluntarily or involuntarily.

Based on his/her performance, he/she (check one): ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

"Active" Service privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, courtesy physician or was moonlighting, a listing of each time period the physician had privileges of your facility should be listed on a separate sheet detailing both dates should be attached to this document, as copies of this form should be copied for each.

Mary F. White
Typed or Legible Print Name (DO NOT USE SIGNATURE STAMPS)

Admin. Assistant II – Medical Staff
Title

5/11/10 Email address: Medical staff/services @ swedish.org
Date (MO/DAY/YR)

(206) 386-2550 (206) 386-3570
Telephone Number Fax Number

Copies of this form may be copied

SWEDISH MEDICAL CENTER

May 11, 2010

Arkansas State Medical Board
2100 Riverfront Dr.
Little Rock, Arkansas 72202

Dear Credentialing Representative:

Membership on the Medical Staff of Swedish Health Services is contingent upon current competency in the privileges granted, compliance with the Bylaws and Rules & Regulation of the Medical Staff and satisfactory participation in the duties and responsibilities of the Medical Staff as assigned.

The following information has been confirmed:

Physician: Dr. Charlie Browne, MD
Initial Appointment: 01/25/2000
Next Appointment: 12/23/2011
Status: Courtesy
Specialty: Ob/Gyn
Privilege Class: privileges

The above named practitioner is/was a member of the Swedish Health Services Medical Staff. Credentialing dates are consolidated for all campuses: First Hill, Providence, Ballard and Issaquah Eastside campus. The initial appointment date is the first date the practitioner was granted privileges on any one of the four campuses. Discrepancies in dates may occur due to merger dates of these facilities.

If this data does not agree with your records or you need additional information, please call the Medical Staff Services Department at 206-386-2550.

Sincerely,

Barbara Lindula Shaw

Barbara Lindula Shaw, CPMSM, BS
Credentials Manager

SWEDISH MEDICAL CENTER
Seattle, Washington

Medical Staff Services
747 Broadway/A-Floor West
Seattle, WA 98122-4307
(206) 386-2550 phone
medicalstaffservices@swedish.org

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

VIRGINIA MASON MEDICAL CENTER
Name of Institution

1100 NINTH AVE, G1-MSO
Street

SEATTLE WA 98101
City State Zip

I, CHARLIE BROWNE, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)

the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize VIRGINIA MASON MEDICAL, its staff, or representative to provide the Arkansas State Medical Board
(Name of Hospital)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, [signature]

Date of Birth: ___ MO ___ DAY ___ YR Social Security Number ___ - ___ - ____

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Evelyn Sinsel, state that the above named physician has/had the following staff privileges
(Print Full Name)

(Circle One): Courtesy - Active Staff - Temporary - Other _____, at our hospital/clinic from 09/07/01 (MO/DAY/YR) to Present (MO/DAY/YR)

Indicate the scope of Clinical Privileges, if any: Gynecology

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed on a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Evelyn Sinsel
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Evelyn Sinsel
Signature

Manager, Medical Staff Services
Title

05/10/2010 evelyn.sinsel@vmmc.org
Date Signed (MO/DAY/YR) Email address:

(206) 583-6430 (206) 625-7237
Telephone Number Fax Number

Rev. 8/18/06 ljm Form may be copied.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

ALL WOMEN'S HEALTH NORTH
Name of Institution

9730 3RD AVE NE, SUITE 200
Street

SEATTLE WA 98115
City State Zip

I, CHARLIE BROWNE (Print Full Name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize ALL WOMEN'S HEALTH NORTH (Name of Hospital), its staff, or representative to provide the Arkansas Sate Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, _____

Date of Birth ___ ___ ___ (MO DAY YR) Social Security Number ___-___-___

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Ashley Stevens (Print Full Name) state that the above named physician has/had the following staff privileges

(Circle One): Courtesy (Active Staff) Temporary - Other _____, at our hospital/clinic from 10 / 29 / 07 (MO DAY YR) to PRESENT (MO DAY YR)

Indicate the scope of Clinical Privileges, if any: MEDICAL DIRECTOR

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Ashley Stevens
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Ashley Stevens
Signature

Office Administrator
Title

05/13/2010 Email address: ashley@aumed.com
Date Signed (MO/DAY/YR)

(206) 935-9553 (206) 935-9806
Telephone Number Fax Number

Rev. 8/18/06 ljm Form may be copied.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

PLANNED PARENTHOOD OF GREATER WASHINGTON & NORTHERN IDAHO
Name of Institution

1117 TETON DRIVE
Street

YAKIMA, WA 98902
City State Zip

I, CHARLIE BROWNE (Print Full Name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize PLANNED PARENTHOOD (Name of Hospital), its staff, or representative to provide the Arkansas Sate Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, _____

Date of Birth ___ MO ___ DAY ___ YR Social Security Number _____

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Sara Cate (Print Full Name) state that the above named physician has/had the following staff privileges (Circle One): Courtesy - Active Staff –Temporary - Other _____, at our hospital/clinic from 2 / 17 / 09 (MO / DAY / YR) to PRESENT (MO / DAY / YR).

Indicate the scope of Clinical Privileges, if any: FULL CLINICAL PRIVILEGES

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Sara Cate MD, MPH
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Sara Cate MD, MPH
Signature

Medical Director
Title

5 / 11 / 2010 Email address: sara.cate@ppgwni.org
Date Signed (MO/DAY/YR)

(509) 576-3685 (509) 576-3685
Telephone Number 961-2762 Fax Number

Rev. 8/18/06 ljm Form may be copied.

HARBORVIEW MEDICAL CENTER
UW Medicine

May 19, 2010

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, Arkansas 72202

RE: Charlie Browne, MD, FACOG

To Whom It May Concern,

This letter serves as an attestation of character and competence and as a recommendation of licensure in the State of Arkansas for Charlie Browne, MD.

I have known Dr. Browne for over 17 years, having met during our initial year at the University of California, Los Angeles School of Medicine in the fall of 1991. We also completed our residency training in Obstetrics & Gynecology at the University of Washington School of Medicine together. Since that time, I have continued to have frequent and in depth contacts with him, both in professional and social capacities. Therefore, I consider my knowledge of him to be well-founded.

Charlie is a dedicated physician, honest professional, and loyal friend who demonstrates maturity and leadership in professional positions. He is extremely dependable and well-liked by patients, physicians, and staff. His competency is excellent, and he continues to demonstrate a high level of skill as a gynecologic surgeon.

I believe that he is and will continue to be successful in his endeavors because of both his personal attributes and skill. His soft-spoken nature along with his sense of fairness are just a few of his commendable traits. I highly recommend him without reservation for licensure in Arkansas. I believe that your medical community will benefit from his presence.

For more information or should you have any specific questions, please do not hesitate to contact me by phone or email.

Sincerely,

Jennifer Melville, MD, MPH, FACOG
Assistant Professor, Obstetrics & Gynecology
jmelvi@uw.edu
(206) 355-2724

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JERRY EDWARDS, M.D.
Medical Director

ANN F. OSBORNE, PA-C
Clinic Director

LORI WILLIAMS, MSN/APN
Associate Clinic Director

To: Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AR 72202

From: Thomas H. Tvedten, MD
4 Office Park Drive
Little Rock, AR 72211
(501) 225-3836 office

Re: Charlie Browne, MD

Seattle, WA 98112

Dear Sirs,

I have known Dr. Charlie Browne for over two years and have known of him for an even longer time. We met at a NAF meeting in Minneapolis where I was impressed with his comments concerning the handling of difficult advanced cases. Since that time Dr. Browne has visited our clinic here in Little Rock and we have continued to share information and ideas. Dr. Browne seems to be a well trained, dedicated and compassionate physician provider and I am sure that he will be an asset to the Arkansas medical community. His expertise in certain areas of gynecologic surgery exceeds that of any provider currently practicing in the state. Therefore, I am recommending him for medical licensure in the state of Arkansas.

Sincerely,

Thomas H. Tvedten M.D.

GroupHealth

Group Health Permanente, P.C.
Partners in health care
with Group Health Cooperative

320 Westlake Avenue N, Suite 100
Seattle, WA 98109

www.ghc.org

May 17, 2010

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, Arkansas 72202

RE: Recommendation of Charlie Browne, MD

Dear Arkansas State Medical Board,

With this letter I am strongly recommendation Dr. Browne for licensure in Arkansas. Charlie is an excellent physician who possess superior clinical as evidenced by his level of knowledge in his field of practice and exemplary physician-patient communication.

Dr. Browne began employment with Group Health Permanente in 2000. During his employment he has not had performance issues.

Please contact me if you need additional information.

Jeffrey Grice, MD
Associate Medical Director, Human Resources
Group Health Permanente

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

June 01, 2010

STATE OF ARKANSAS
2100 RIVERFRONT DR
LITTLEROCK AR 72202

Subject: Credential Verification

To Whom It May Concern:

This will verify the status of the Physician And Surgeon License for CHARLIE BROWNE.

Sections may be blank because the information is not in our database or is not applicable for this credential type.

Year of Birth:	
Credential Number:	MD.MD.00035431
Credential Type:	Physician And Surgeon License
Current Credential Status:	ACTIVE ACTIVE
First Credential Date:	09/02/1997
Expiration Date:	01/10/2011
Last Renewal Date:	
Examination:	
Exam Level:	
Score:	

Our records above show that the licensee has not been disciplined, the licensee is considered in good standing

Please call me at (360) 236-2766 if you have questions or visit our Online Provider Credential Search at www.doh.wa.gov.

Betty Elliott

Betty Elliott, Acting Licensing Manager

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

ARKANSAS RULES AND REGULATIONS
AFFIDAVIT

I, CHARLIE BROWNE (Type or Print Name) on this date, 5-5-10.

do affirm that I have read the Medical Practices Act, Arkansas Code 17-95-101, *et seq.*, and the Rules and Regulations of the Arkansas State Medical Board.

Signed: _____ (Physician's Signature)

Date: 5-5-10

THIS IS A REQUIREMENT FOR LICENSURE. YOU MUST COMPLETE THIS FORM AND RETURN IT TO:
ARKANSAS STATE MEDICAL BOARD
ATTN: LICENSING
2100 RIVERFRONT DRIVE
LITTLE ROCK, AR 72202-1435

CURRICULUM VITAE

Charlie Browne, M.D., F.A.C.O.G.

PERSONAL DATA

Home Address	Seattle, WA 98112
Office Address	9730 3rd Ave NE, Ste 200 Seattle, WA 98115
Birthplace	Bridgetown, Barbados

ACADEMIA

Accreditation Association for Ambulatory Health Care Wilmette, IL Accreditation Surveyor	2002
Department of Obstetrics and Gynecology Virginia Mason Medical Center, Seattle, WA Pelvic Surgery Fellow	2001
Department of Obstetrics and Gynecology University of Washington Medical Center, Seattle, WA Ob/Gyn Resident	1999
Drew/UCLA Medical Program UCLA School of Medicine, Los Angeles, CA M.D.	1995
American Association of Pathologists' Fellowship Kaiser Permanante Medical Center, Los Angeles, CA	1993
Medical Genetics Fellowship Cedars-Sinai Medical Center, Los Angeles, CA	1992
Psychobiology UCLA, Los Angeles, CA B.S.	1991
Physical Sciences Program Long Beach City College, Los Angeles, CA A.S.	1985

LICENSURE

Washington State	1997

BOARD CERTIFICATION

Diplomate, American Board of Obstetrics and Gynecology	2001

PROFESSIONAL POSITIONS

Medical Director All Women's Health North Seattle, WA	10/07 - Present
Clinic Provider Planned Parenthood of Greater Washington & Northern Idaho Yakima, WA	02/09 - Present
Gynecologic Surgeon Group Health Cooperative Seattle, WA	07/99 - Present
Surveyor (Chairperson Privileges) Accreditation Association for Ambulatory Health Care Wilmette, IL	2002 - Present
Clinical Instructor University of Washington Medical Center Seattle, WA	07/99 – 10/05
Attending Physician Women's Clinic Harborview Medical Center Seattle, WA	07/99 – 10/05
Clinic Provider Planned Parenthood of The Great Northwest Seattle, WA	06/99 – 11/00
Consulting Physician Glaser Family Medicine Dysplasia Clinic Swedish Medical Center Seattle, WA	01/99 – 12/02

HOSPITAL PRIVILEGES

Group Health Cooperative – Active Seattle, WA	07/20/99 - Present
Virginia Mason Medical Center – Courtesy Seattle, WA	07/20/99 - Present
Swedish Medical Center – Courtesy Seattle, WA	01/25/00 - Present
University of Washington Medical Center Seattle, WA	07/01/99 – 10/01/05
Harborview Medical Center Seattle, WA	07/01/99 – 10/01/05

LEADERSHIP POSITIONS

Board of Directors Member The Bra Show Seattle, WA	2006 - 2009
Mentor Summer Medical Education Program UW School of Medicine, Seattle, WA	2002 - Present
Mentor U-DOC High School Program UW School of Medicine, Seattle, WA	1997 - Present
Primary Advisor Advisory Group for the Domestic Violence & Child Protection Services Project King County Department of Health, Seattle, WA	1997 – 2001
Moderator SPARX Panel on Domestic Violence UW School of Medicine, Seattle, WA	1998 - 1999
President Medical School Class Drew/UCLA Medical Education Program, Los Angeles, CA	1994 - 1995
Clinic Coordinator Inner-city Student-Managed Free Clinic UCLA, Los Angeles, CA	1994 - 1995
Student Representative Biomedical Ethics Committee UCLA, Los Angeles, CA	1994 - 1995
President American Geriatric Society Student Chapter UCLA, Los Angeles, CA	1994
Counselor Suicide Prevention Crisis Line Family Services of Los Angeles, CA	1994
Moderator South Central Youth Congress, Los Angeles, CA	1993 - 1995
Member Committee on Admissions Drew/UCLA Medical Education Program, Los Angeles, CA	1993 - 1995
Member Medical Education Committee UCLA, Los Angeles, CA	1993 - 1995
Member University's Institution Education Programs Committee Drew University of Medicine & Science, Los Angeles, CA	1993 - 1995
Coordinator Symposium on Battered Women Martin Luther King Medical Center, Los Angeles, CA	1992

Coordinator
Men Taking Action Against Rape
UCLA, Los Angeles, CA 1990 - 1991

RESEARCH EXPERIENCE & PRESENTATIONS

Lecturer
"Providing Services for Obese Patients"
NAF 32nd Annual Meeting
Minneapolis, MN 2008

Lecturer
"Recognition & Management of Domestic Violence in Primary Care"
Update in Primary Care: 3rd Annual Conference
Seattle Research Association, Seattle, WA 1999

"The Mother's Maneuver: Making the Diagnosis of a Potentially Viable Pregnancy in an Emergent Situation"
Collaborators: Leslie Miller, MD; Gregory Jurkovich, MD
UWMC, Seattle, WA 1999

"Comparison of Pregnancy Rates of Minimum Stimulation with Standard Source Protocol in the Treatment of Infertility"
Collaborators: Nancy Klein, MD
UWMC, Seattle, WA 1998

"Bone Aging in Achondroplasia Individuals"
Collaborators: Ralph Lachman, MD; David Rimoin, MD
International Skeletal Dysplasia Registry, Los Angeles, CA 1995

NIH Research Fellow
Hypertension in Twins Study, Barbados.
Collaborators: Clarence Grim, MD; Rasha Soliman, MD
Drew University of Medicine & Science, Los Angeles, CA 1994

"Prenatal Diagnosis of the Skeletal Dysplasias"
Collaborators: Rueben Sharony, MD; Ralph Lachman, MD; David Rimoin, MD
Cedars-Sinai Medical Center, Los Angeles, CA 1993

"Laterality of Verbal & Auditory Stimuli in Split-Brain Patients"
Collaborators: Sarah Spence, MD, Oren Zaidel, PhD
UCLA, Los Angeles, CA 1990

PROFESSIONAL AFFILIATIONS

Fellow
American College of Obstetricians and Gynecologists 2001 - Present

Member
The Society of Laparoendoscopic Surgeons 2002 - Present

Educational Affiliate
American College of Obstetricians and Gynecologists 1999 - 2001

Associate Fellow
American College of Surgeons 2000 - 2001

PUBLICATIONS

Sharony R, Browne C, Lachman RS, Rimoin DL: Prenatal Diagnosis of the Skeletal Dysplasias. *Am J Obstet Gynecol* 1993;169:668-675.

HONORS/AWARDS

Service Star Award Group Health Cooperative	2002 & 2003
Patient Satisfaction Survey Award Group Health Cooperative	2003
Certificate Of Appreciation For Teaching Family Medicine Department, Group Health Cooperative	2002
"I Want To Be Like That Person" Award 4th Year Medical School Class, UW School of Medicine	1997
Leroy R. Weekes Award For Excellence in Obstetrics & Gynecology Drew/UCLA Medical Program	1995
Mackenzie Foundation Scholarship UCLA School of Medicine	1993 - 1995
Who's Who Among Students in American Universities & Colleges	1993
Student Award Research Training (START) Scholarship UCLA	1990