Initial Medical Licensure
PERSONAL INFORMATION
12/2015 INT

STOP! Completed application and check must be mailed to.
MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-1298 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date
Check Number
Amt Paid 790.00
Name Code
AppID 17

APPLICATION FOR INITIAL MEDICAL LICENSURE

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.): BROWNE

First name and middle name: CHARLIE

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name

Stop! **If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.**

2. **Public Address:** Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**

9730 3RD AVE NE
SUITE 200

City: SEATTLE State: WA Zip Code: 98115-

3. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

Street Address: **(Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**

City State Zip Code

4. **Telephone (s):** Home

Office: 206-985-9553

Cell/Pager:

E-mail address:

5. **Date of Birth:** Month Day Year

6. **Gender:** ☐ Male ☐ Female

7. **Race:** Multiracial applicants may select all applicable categories ___ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ___ White

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino

8. **Social Security Number:** - -

For Board Use Only	License Number: D82699	BPQA School Code: 065014
	Date Issued: DEC 21 2016	Federation School Code:
	Licensed By:	Licensing Exam:

5

Initial Medical Licensure
CHRONOLOGY
12/2015 INT

Print Your Name: CHARLIE BROWNE Date: 8-1-16

9. Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

EMPLOYMENT: SEE APPLICANT'S EXPLANATION ✗

Date Medical School was Completed: month 05 year 95

Activities after completing medical school: Please type or print.

From (month/year)	To (month/year)	Activity	Address
06/95	05/99	RESIDENT - UNIVERSITY OF WASHINGTON OB-GYN	PACIFIC ST., SEATTLE, WA
✗ 07/99	06/01	FELLOWSHIP - VIRGINIA MASON MEDICAL CENTER GYNECOLOGIC SURGERY	1100 NINTH AVE, SEATTLE, WA
01/99	12/02	ATTENDING PHYSICIAN	SWEDISH FAMILY MEDICINE DYSPLASIA CLINIC 1401 MADISON ST, SUITE 100 SEATTLE, WA 98104
07/99	10/05	ASSOCIATE MEDICAL STAFF	HARBORVIEW MEDICAL CENTER 325 NINTH AVE, SEATTLE, WA 98104
07/99	10/05	ASSOCIATE MEDICAL STAFF	UNIVERSITY OF WASHINGTON MEDICAL CENTER 1959 NE PACIFIC ST, SEATTLE WA 98195
07/99	08/16	MEDICAL STAFF	VIRGINIA MASON MEDICAL CENTER 1100 NINTH AVE, G1-MSO SEATTLE, WA 98101
07/99	08/16	MEDICAL STAFF	GROUP HEALTH COOPERATIVE 310 15TH AVE E, CMB-2 SEATTLE, WA 98112
07/99	12/00	STAFF PHYSICIAN	PLANNED PARENTHOOD OF THE GREAT NORTHWEST 2001 EAST MADISON ST., SEATTLE WA 98122

CONTINUED ON PAGE 3: **If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.**

Initial Medical Licensure
CHRONOLOGY
12/2015 INT

Print Your Name: CHARLIE BROWNE   Date: 8.1.16

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

From (month/year)	To (month/year)	Activity	Address
01 00	08 16	MEDICAL STAFF	SWEDISH MEDICAL CENTER 747 BROADWAY, SEATTLE WA 98122
11 02	12 14	ACCREDITATION SURVEYOR AAAHC	ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE 5250 OLD ORCHARD RD, STE 200 SKOKIE, IL 60077
10 07	08 16	MEDICAL DIRECTOR	ALL WOMEN'S HEALTH NORTH 9730 3RD AVE NE, SUITE 200 SEATTLE, WA 98115
02 09	08 16	STAFF PHYSICIAN	PLANNED PARENTHOOD OF GREATER WA AND NORTH IDAHO 1117 TIETON DR, YAKIMA WA 98902
08 10	08 16	CLINIC PHYSICIAN	LITTLE ROCK FAMILY PLANNING SERVICES 4 OFFICE PARK DRIVE, LITTLE ROCK, AR 72211
06 16	08 16	CLINICAL ASSISTANT PROFESSOR	UNIVERSITY OF WASHINGTON MEDICAL CENTER 1959 NE PACIFIC ST., SEATTLE, WA 98195
06 14	08 16	COMMISSIONER MEDICAL QUALITY ASSURANCE COMMISSION	WA STATE DEPARTMENT OF HEALTH P.O. BOX 47866, OLYMPIA WA 98504-7866

Print Your Name: CHARLIE BROWNE Date: 8.1.16

10. MEDICAL EDUCATION: List all medical schools you have attended From: MM/YY To MM/YY

UNIVERSITY OF CALIFORNIA AT LOS ANGELES (UCLA) 08/91 TO 05/95

Medical School From Which You Received Your Medical Degree: UCLA - DREW MEDICAL PROGRAM

Name of University Affiliation (if applicable): * UCLA

Street Address: 1621 EAST 120TH ST.

City: LOS ANGELES **State/Province:** CA **Country of citizenship during medical education:** USA

Language(s) of Instruction: ENGLISH

Type of Degree: ☒ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other:_______ (specify)

Date Degree The date you officially received your degree after all prerequisite obligations, required training, government service, etc.
Was Conferred: was satisfied. Month 05 Day 31 Year 95

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)
Attach the following documents to this application:

N/A

1) **A copy of your valid ECFMG certificate or Fifth Pathway Certificate;**

2) **A copy of your medical school diploma and a certified translation;**

3) **If you listed an affiliation above (see * in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation .**

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. How have you satisfied Maryland's *written* and *oral* English language competency requirements?
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. ☒ I graduated from a medical school **or**, after at least three years of attendance, a high school (includes GED), undergraduate college, or university **where English was the *only* language of instruction throughout** (you must provide documentation); **or**

b. I passed either ☐ the TOEFL **or** ☐ the ECFMG English test after December 31, 1973 **AND** I passed the ☐ TSE or ☐ OPI. If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board;

c. I passed the USMLE Step 2 Clinical Skills Exam.

Are you claiming speech impairment? NO YES If "YES," please write or call the Board for additional information.

Print Your Name: CHARLIE BROWNE Date: 9-19-16

12. POSTGRADUATE TRAINING (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order ALL postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider full time teaching in an LCME accredited medical school in the United States as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a U.S. postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this appli-

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education *after* successfully completing a Board approved Fifth Pathway program. If you have not met these two critera, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete 2 years of U.S. postgraduate training. If you have not met this requirement, DO NOT submit this application.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

PG Year #s	Place of Training / Address	Specialty	From (month/year)	To (month/year)	Accredited by: ACGME / AOA / RCPSC
1-4	Place of Training: UNIVERSITY OF WASHINGTON		06 95	06 99	
	Address: PACIFIC ST. SEATTLE, WA	OB-GYN			ACGME ☐ AOA ☐ RCPSC ☐
5-6	Place of Training: VIRGINIA MASON MEDICAL CENTER		07 99	06 01	
	Address: 1100 NINTH AVE, G1-MSO, SEATTLE, WA	GYN SURGERY			ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training:				
	Address:				ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training:				
	Address:				ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training:				
	Address:				ACGME ☐ AOA ☐ RCPSC ☐

EMPLOYMENT: SEE APPLICANT'S EXPLANATION *

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

Print Your Name: CHARLIE BROWNE Date: 8.1.16

12. POSTGRADUATE TRAINING (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order ALL postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider **full time teaching in an LCME accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a U.S. postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this appli-

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education *after* successfully completing a Board approved Fifth Pathway program. If you have not met these two critera, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete 2 years of U.S. postgraduate training. If you have not met this requirement, DO NOT submit this application.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

PG Year #s	Place of Training / Address	Specialty	From (month / year)	To (month / year)	Accredited by
1-4	Place of Training: UNIVERSITY OF WASHINGTON Address: PACIFIC ST, SEATTLE, WA	OB-GYN	06 / 95	05 / 99	ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training: Address:		/	/	ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training: Address:		/	/	ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training: Address:		/	/	ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training: Address:		/	/	ACGME ☐ AOA ☐ RCPSC ☐

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

Initial Medical Licensure HOSPITAL PRIVILEGES 12/2015 INT	Print Your Name: CHARLIE BROWNE	Date: 8.1.16

13. Hospital Privileges After Postgraduate Training: Please list all hospitals where you have had privileges or have provided services **after the completion of your postgraduate training** for the five year period preceding the filing of this application. Copy this page if more space is needed and enclose each signed and dated addition.

Hospital	Complete Address	From (month/year)	To (month/year)	Department
GROUP HEALTH COOPERATIVE	310 15TH AVE E., SEATTLE, WA 98112	07 99	08 16	OB-GYN
VIRGINIA MASON MEDICAL CENTER	1100 NINTH AVE, SEATTLE, WA 98101	07 99	08 16	OB-GYN
SWEDISH MEDICAL CENTER	747 BROADWAY, SEATTLE, WA 98122	01 00	08 16	OB-GYN

Print Your Name: CHARLIE BROWNE Date: 8·1·16

14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send complete medical licensing examination history and scores directly to this Board. In each examination category below, you will information to help you contact the administering authority.

a. Have you ever failed any medical licensing examination (or part, step, or component thereof)? NO YES

b. Have you failed any medical licensing examination (or part, step, or component thereof) three or more times? NO YES

If you answered "Yes" to a. and b., you must have successfully completed 2 years of ACGME-accredited clinical postgraduate training. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.

For a complete explanation see COMAR 10.32.01.03 Licensure—Qualifications for Initial Licensure

a. **State Board Examination** List state(s): ______

STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. State Board Examinations taken after December 31, 1984 are not accepted for licensure in Maryland.

Send a copy of MBP IML7, *State Board Licensure and Examination Certification,* form to the state(s) which administered your licensing exam and a the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a licen...

NOTE: Many states charge a fee for exam transcripts. Contact each state board prior to sending form IML7, as all fees are the responsibility of the applicant.

NOTE: This section is not relating to National Board Certification.

Federation of State Medical Boards (See Page 8 if you took a combination of these exams or combined either with the NBME exams)

b. FLEX-Weighted Average: **All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c. FLEX Components 1 and 2: **Examinations must be passed within 5 years of each other.**

d. USMLE Steps 1, 2, and 3: **Successfully passing all parts of the examination.**

If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at www.fsmb.org. *Click transcript requests.*

e. **National Board of Medical Examiners** (See Page 8 if you combined this examination with FLEX or USMLE exams)

If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification ***and*** the Record of Scores. All requests must be made through the NBME website at **http://www.nbme.org** or call 215-590-9592. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f. **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.** If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g. **Medical Council of Canada**

Licentiate of the Medical Council of Canada

Please request that verification of your Licenciate Certification and a complete LMCC examination history be sent directly to this Board. Call MCC at 613-521-6012 for instructions and fee information.

CONTINUED ON PAGE 8

Initial Medical Licensure MEDICAL EXAMS 12/2015 INT	Print Your Name: CHARLIE BROWNE	Date: 8.1.16

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

h. ☐ USMLE 1 + NBME II + NBME III

i. ☐ USMLE 1 + USMLE 2 + NBME III

j. ☐ USMLE 1 + NBME II + USMLE 3

k. ☐ NBME I + USMLE 2 + USMLE 3

l. ☐ NBME I + USMLE 2 + NBME III

m. ☐ NBME I + NBME II + USMLE 3

n. ☐ FLEX 1 + USMLE 3

o. ☐ FLEX 2 + USMLE 1 + NBME II

p. ☐ FLEX 2 + USMLE 1 + USMLE 2

q. ☐ FLEX 2 + NBME I + USMLE 2

r. ☐ FLEX 2 + NBME I + NBME II

- If your hybrid exams included any part of the NBME examination, contact NBME at **http://www.nbme.org** or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Maryland Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at www.fsmb.org.

15. Licensing History:

a. ☐ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b. ☐ I have an application for license pending in the following states: _____, _____, _____, _____, _____

c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.

d. Has any disciplinary action ever been taken against your license? ☒ No ☐ Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked
WA	MD 35431	✓					
AR	E-6577	✓					

(If more space is needed, please attach an additional signed and dated sheet.)

Initial Medical Licensure
Release and Certification
12/2015 INT

RELEASE AND CERTIFICATION

19. Release:

I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

CHARLIE BROWNE ______ 8.19.16

Applicant's Name (Printed) Applicant's Signature Date

20. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release. Please know that without this release, no one will be able to receive information concerning your file.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: ______

Phone: ______ 8.19.16

21. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

______ 8.19.16

Applicant's Signature Date

22. Affidavit: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-22 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

______ 8.19.16

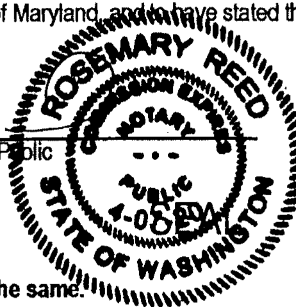
Applicant's Signature Date

STATE OF Washington

CITY/COUNTY OF King

I HEREBY CERTIFY that on this 19th day of August, 20 16, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, Charlie Browne (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this applica"

AS WITNESS my hand and notorial seal. ______ Notary Public



My Commission expires: 04-07-2020

*** Applicant signature date and notary signature date should be the same.**

STOP! Completed application and check must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297