PHYSICIAN'S CORE DATA SHEET

(*Must be the physician's accurate information to avoid delay or rejection*)

Full Legal Name Jamie (First), Michele (Middle), Phifer (Last), _____ (Suffix(Sr., Jr.))
(Exactly as on DL or Passport)

Other names used(maiden, birth) _____ (First) _____ (Middle) _____ (Last)

Mailing address 701 5th Ave STE 2300 (Mailing address), Seattle (City), WA (State(XX)), 98104 (Zip)

Office address 701 5th Ave STE 2300 (Office address), Seattle (City), WA (State(XX)), 98104 (Zip)

Date of Birth _____/1985 (mm/dd/yyyy) Gender: Male Female x

Physician's office or practice telephone number of public record 866-657-7991 (###-###-####)

Physician's cellular or alternative telephone number _____ (###-###-####)

Email address delegated by applicant to receive correspondence _____

Social Security Number: _____ (###-##-####)

Physician's National Provider Identifier Number _____

Medical Degree Received: M.D. x D.O.

(Medical school must be accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or be listed in the International Medical Education Directory or its equivalent.)

Medical School University of Florida College of Medicine
Name of School (no abbreviations or acronyms)

Date of Degree Issued 05/14/2011 (mm/dd/yyyy)

Physicians must have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. (NOTE: One-year transitional residencies do not meet this requirement)

Residency Program Swedish Cherry Hill Family Medicine (Full Program Name (no abbreviations or acronyms)) Completion Date 06/24/2014 (mm/dd/yyyy)

What is the specialty of the program Family Medicine

Qualifying Licensing exam taken: USMLE x COMLEX Other _____
Must specify by name

Number of attempts taken to pass the USMLE:

Step 1: 1 Step 2 CS: 1 Step 2 CK: 1 Step 3: 1

Number of attempts taken to pass the COMLEX:

Step 1: ____ Step 2 PE: ____ Step 2 CE: ____ Step 3: ____

Number of attempts taken to pass other licensing exam:

Step 1: ____ Step 2: ____ Step 3: ____

Specialty Board Certification must be by an ABMS or AOABOS board.

Specialty Board Certification: American Board of Family Medicine
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

In Process

Lifetime:

Time limited: x Expiration date of time limited 06/25/2024
(mm/dd/yyyy)

Physicians must possess a full and unrestricted medical license issued by an IMLC Member Board.

License # MD60359609 Date of Original Licensure 07/05/2013 (not renewal)
(mm/dd/yyyy)

Expiration Date 08/25/2020 Status of License: Current: x Not Current:
(mm/dd/yyyy)

Thank you for applying through the Interstate Medical Licensure Compact.

*The state will contact you to give instructions on obtaining your fingerprints for a criminal background check. **YOU HAVE 60 DAYS TO COMPLY WITH REQUESTS FROM THE STATE** to avoid automatic withdraw. Background checks may take some time, so please be patient. If you have any concerns contact your SPL. SPL contact numbers can be found at www.IMLCC.org. You will receive an email regarding the status of your qualification. Be sure to check your spam folder and set your email to accept messages from the @docusign.net and @docusign.com domains.*

RECEIVED
FEB 06 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

FOR USE OF STATE OF PRINCIPAL LICENSE

I have conducted the verification process of this physician's application.

State Authorized Signature DocuSigned by: Kimberly M Romero A9E71BFB17A64C1...

Type Name Kimberly M Romero

Title Licensing Manager

Warning: The signature tab will default to your Board's name. Please change it to your name in Adopt and Sign.

CORE DATA CORRECTION SHEET

To process corrections please use the below freeform text boxes. The corrections will be passed to the Member Boards selected to issue licenses. If you use this sheet there is no need to send any correction emails.

Core Data to be changed	Incorrect data	Correction
		06/30/2014
GME-Swedish Cherry Hill	06/24/2014	06/30/2014
ABMS	6/25/2024	MOC- 02/15/2020

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Jamie (First Name) Michele (Middle Name) Phifer (Last Name)

Please fill in your respective Member Board's information for the qualified Physician named above.

National Provider Identifier Number _____

Medical Board Name Colorado Medical Board

Member Board License Number CDR.0000560

Date License Issued 11/20/2019 (mm/dd/yyyy)

Date of Expiration 04/30/2021 (mm/dd/yyyy)

Warning: The signature tab will default to your Board's name. Please change it to your name in Adopt and Sign

Member Board Signature DocuSigned by: COLORADO MEDICAL BOARD 729A52A251304CC...

Type Name Shannon Davidson

DATE 11/20/2019 | 10:32 CST

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Jamie (First Name) Michele (Middle Name) Phifer (Last Name)

Please fill in your respective Member Board's information for the qualified Physician named above.

National Provider Identifier Number _____

Medical Board Name Arizona Medical Board

Member Board License Number 60032

Date License Issued 11/20/2019 (mm/dd/yyyy)

Date of Expiration 12/25/2021 (mm/dd/yyyy)

Warning: The signature tab will default to your Board's name. Please change it to your name in Adopt and Sign

Member Board Signature DocuSigned by: Mary Dunavant 23A3268E0F3346B...

Type Name Mary Dunavant

DATE 11/20/2019 | 12:54 CST

QUALIFICATIONS APPLICATION

If you do not complete the application process you will be sent an email with a link to log back in to complete the documents. Be sure to look in your SPAM and JUNK folders. To apply for a Letter of Qualification for licensure through the Interstate Medical Licensure Compact please answer the questions below.

IS THIS A RE-APPLICATION(earned an LOQ in the past and now is reapplying)? YES NO X

1. Which IMLC Member State do you want to serve as your State of Principal License (SPL)?: WASHINGTON M.D.

2. Do you hold a full and unrestricted medical license to engage issued by a medical licensing board in the SPL (SPL Board) WASHINGTON MEDICAL COMMISSION? Yes X No

3. What is the license number issued to you by the SPL board? MD60359609

4. Which of the following apply to you(at least one must apply)?

a. Your primary residence is in the SPL WASHINGTON M.D.: Yes No X

If yes, provide the following:

Residence Street address _____

Residence City State Zip _____ (City), _____ (St), _____ (Zip)

b. At least 25% of your practice of medicine occurs in the SPL WASHINGTON M.D. Yes No X

If yes, describe your current practice _____

_____

c. Your employer is located in the SPL WASHINGTON M.D.: Yes X No

If Yes, Employer name 98point6

Employer street address 701 5th Ave STE 2300

Employer City State Zip Seattle (City), WA (St), 98104 (Zip)

d. You have designated the SPL WASHINGTON M.D. as your state of residence for U.S. federal income tax purposes: Yes No X

If yes, give Tax ID # (SS#, EIN) _____ (must be most recent return)

5. Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes x No

6. Have you passed each component of the United State Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes(if in question contact your SPL)? Yes x No

7. Have you successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association? Yes x No

8. Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? Yes x No

(Please note that answering any of the following questions with a "YES" will result in your application being denied per eligibility Rule 5.4. If eligibility is in question please contact the state board directly for information regarding application through the traditional method.)

9. Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? Yes No x

10. Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? Yes No x

11. Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? Yes No x

12. Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? Yes No x

Physician's Signature: DocuSigned by: [redacted] 59A38FF83913468...

Type Name: Jamie Michele Phifer

Date: 10/10/2019 | 5:56 CDT

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN IMLC LETTER OF QUALIFICATION AND MEDICAL LICENSES IN IMLC MEMBER STATES

I, Jamie Michele Phifer (Type in full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as my being prosecuted under appropriate federal and state laws.

I hereby apply to WASHINGTON M.D. as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I hereby authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the SPL any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the SPL or any of its agents or representatives to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the SPL.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application, and further authorize the SPL to process my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a Letter of Qualification, and revocation, or other disciplinary sanction, of my license(s) or permit(s) to practice medicine in one or more Compact Member States.

Applicant Signature DocuSigned by: [illegible] 59A38FF83913468...

Type Applicant's Name Jamie Michele Phifer

Applicant's NPI 1154615185

DATE 10/10/2019 | 5:56 CDT

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR MEDICAL LICENSES IN IMLC MEMBER STATES

I, Jamie Michele Phifer (Type in full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect, that I hold a current and valid IMLC Letter of Qualification ("LOQ") issued on (Date) 11/19/19 by (SPL) WASHINGTON M.D. as my State of Principal License, and that I continue to meet all requirements to qualify for the LOQ.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as my being prosecuted under appropriate federal and state laws.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application, and further authorize the SPL and the Compact Commission ("Commission") to process my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind arising out of any disclosure to the Member Boards.

I will immediately notify the SPL, the Member Boards, and the Commission in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a medical license being issued by one of more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application, and revocation, or other disciplinary sanction, of my license(s) or permit(s) to practice medicine in one or more Compact Member States.

Physicians Signature DocuSigned by: [signature] 59A38FF83913468...

Type Physician's Name Jamie Michele Phifer

Applicant's NPI _____

DATE 2/5/2020 | 3:48 CST

You will receive one or more emails regarding the status of your application(s) for license(s) from Member Board(s). If you have any concerns contact the Member Board(s) directly. Member Board contact information is on the www.IMLCC.org website. Be sure to check your spam folder and set your email to accept messages from the @docusign.net and @docusign.com domains.

Thank you for applying through the Interstate Medical Licensure Compact.

All fees are non-refundable

ch_1G8vevJl1O8IBBVti81uGJ6V

Letter of Qualification Verification

A review of records of the (Board) Washington Medical Commission indicates that (Physician Name) Jamie Michele Phifer holds a Letter of Qualification for licensure in Member States of the Interstate Medical Licensure Compact. The Letter of Qualification was issued on (Issue Date) 11/19/2019 and will be valid for 365 days from that date.

(Board) IMLCC

DocuSigned by:
Marschall S. Smith
382E3[redacted]
Signature

David Clark
Type Name

Customer Liaison Manager
Title

2/5/2020 | 4:25 CST
Date

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive Reno, Nevada 89521 Phone (775) 688-2559

Licensee Name: Jamie Phifer
(Please print and indicate your legal name)

Licensee Address: 701 5th Ave STE 2300

City, State, Zip: Seattle, WA 98104

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FEB 24 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Attestations/Affirmations:

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

✓ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. ✓ Yes _____ No

http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. ✓ Yes _____ No

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

Malpractice Questions:

1. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?

____Yes ✓ No

1a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?

____Yes ✓ No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you have not answered "yes" to questions #1 and/or #1a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your required supplemental items.

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FEB 24 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Name of patient involved:

In which state did the action take place? N/A

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

Open Closed (settled or judgment) Dismissed (no money paid out) Other

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement $:

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? Primary defendant Co-defendant Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

HOSPITAL QUESTION:

List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all) resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To
(Mo. /Yr.)	N/A			

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FEB 24 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

(All information must begin on the form, if more space is needed, please attach separate sheet.)

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States.

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: Jamie Phifer

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? _____Yes ✓ No

If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

2-If yes, which branch of service did you serve?
- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard

3-Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

4&5-Dates of service in the Military: 4-From: ____/____/____ (DD / MM / YYYY) 5-To: ____/____/____ (DD / MM / YYYY)

6-Are you still serving? _____Yes _____No

7-Have you ever served on active duty in the Armed Forces of the United States? _____Yes _____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____Yes _____No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged your answer should be "yes.") _____Yes _____No _____N/A

HOSPITAL QUESTION:

List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all) resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo. /Yr.)
N/A			

RECEIVED
MAR 09 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

(All information must begin on the form, if more space is needed, please attach separate sheet)

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States.

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: Jamie Phifer

Signature of Applicant/Licensee: _____

Electronic Mail Address [redacted]

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? _____Yes ✓ No

If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

2-If yes, which branch of service did you serve?

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard

3-Military occupation specialty or specialties?

- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

4&5-Dates of service in the Military:

4-From: ____/____/____ (DD / MM / YYYY) 5-To: ____/____/____ (DD / MM / YYYY)

6-Are you still serving? _____Yes _____ No

7-Have you ever served on active duty in the Armed Forces of the United States? _____Yes _____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____Yes _____No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged your answer should be "yes.") _____Yes _____No _____N/A

LICENSEE PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

Signature of Licensee

2/18/2020
Date

RECEIVED
FEB 24 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Letter of Qualification

IS THIS A RE-APPLICATION? YES NO X

Date 11/19/2019
mm/dd/yyyy

Name: Jamie Michele Phifer

Address: 701 5th Ave Ste 2300

CityStZip Seattle WA 98104-7041

Dear Dr. Phifer:

RE: Your application for IMLC Letter of Qualification

The WASHINGTON MEDICAL COMMISSION ("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL DocuSigned by: Kimberly M Romero A9EZ1BFB17A64C1...

Type Name Kimberly M Romero

Title of Authorized SPL Licensing Manager

DATE 11/19/2019 | 8:57 CST