DATE	TELEPHONE LOG	INITIALS

Physician Application Worksheet

Pending Number ______
License Number ______

Name: Browne, Charlie
Date of Birth: 1-10-63

Date Received: 7/25/97 Date Completed: 8-28-97 Signature ______

✓ Fee	✓ Photo	✓ Personal Data	✓ AIDS	✓ Affidavit	☒ Archive File

Chronology: ✓ Complete

Missing: ___ to ___ / ___ to ___ / ___ to ___

☐ Temporary Permit Requested ______ Status

FSMB	AMA	ECFMG	Reinstatement
8/4	8/20		

Personal Data Questions	Documentation Received

Malpractice Cases	Synopsis	Original Complaint	Disposition
1			
2			
3			
4			

Medical School

☒ U.S. ☐ Canadian ☐ International

Name: UCLA Year of Degree: 1995

☒ Transcripts ☐ Translations

Examination Type: ☐ National Boards ☐ FLEX ☒ USMLE ☐ State Exam ☐ LMCC 8/4 Scores Received

Received	Post Graduate Training Programs	Accreditation Verified	Received	Post Graduate Training Programs	Accreditation Verified
7/23	U of W	6/95-6/99			

Received	State Licensure

Received	Hospital Privileges

Approved: Susan Anthony (Signature) Date: 9-2-97

Comments:

100

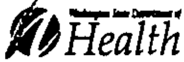
PHYSICIAN & SURGEON

REVENUE SECTION

PRINT NAME Browne, Charlie

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236



Washington State Department of Health
Health Professional Quality Assurance Division
PO Box 1099
Olympia WA 98507-1099
(360) 753-2844
(360) 664-8689

RECEIVED
JUL 25 1997
HPQA

APPLICATION FOR LICENSE TO PRACTICE MEDICINE
APPLICABLE FOR MD'S ONLY

All applications must be accompanied by applicable fee (fees are non-refundable).

All applicants carefully follow all instructions in general instructions.

It is the responsibility of the applicant to submit or request to have submitted, all required supporting documents.

Licensure Examination Taken (check one): ☐ National Board ☐ ____________ State Examination ☐ LMCC (must have been obtained after 1969)
☐ FLEX Examination ☒ USMLE Examination

For Office Use Only		
Certificate No. 35431	Issue Date	Expiration Date

Please Type or Print Clearly

Applicant's Name BROWNE (LAST) CHARLIE (FIRST) ____ (MIDDLE INITIAL)

Mailing Address 2319 E. LYNN

City SEATTLE, WA State WA Zip 98112 County KING

Telephone (206) 543-3580
ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS

Social Security Number 22 Licensee SSN
REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND NOT REQUIRED FOR LICENSING APPROVAL

Home Address 2319 E. LYNN (STREET) SEATTLE (CITY) WA (STATE) 98112 (ZIP)

Sex (F or M) M Birthdate 01 (MONTH) 10 (DAY) 63 (YEAR) Birthplace BRIDGETOWN (CITY), (STATE) BARBADOS (COUNTY)

Medical Speciality OBSTETRICS AND GYNECOLOGY

Medical School UCLA (NAME) Year of Graduation 1995

Have you previously applied for a Washington State License or limited license? ☒ Yes ☐ No

List other name(s) that appear on documents or credentials —

PERSONAL DATA

Question	Yes	No
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒

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

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

Question	Yes	No
2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒

"Currently" means recently enough so that the use of drugs may have an ongoing impact in one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, <u>including</u> those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

Question	Yes	No
3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☒
4. Are you currently engaged in the illegal use of controlled substances?	☐	☒

"Currently" means recently enough so that the use of drugs may have an ongoing impact in one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

Question	Yes	No
5. Have you ever been convicted, entered a plea of guilty, nolo contendere, or a plea of similar effect, or had prosecution or sentence deferred or suspended in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☒
b. a charge of a sex offense?	☐	☒
c. any other crime, other than minor traffic infractions? (Include driving under the influence and reckless driving.)	☐	☒
6. Have you ever been found in any civil, administrative, or criminal proceeding to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances of legend drugs, violated any drug laws, or prescribed controlled substances for yourself?	☐	☒
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☒
c. violated any state or federal law or rule regulating the practice of a health care profession?	☐	☒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgements, decisions, and agreements.	☐	☒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked suspended, or restricted by a state, federal, or foreign authority or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☒
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☒

PERSONAL DATA QUESTIONS (Continued)

	Question	Yes	No
10.	Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☒
11.	Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☐	☒
12.	To the best of your knowledge, are you the subject of an investigation by any licensing board as of the date of this application?	☐	☒
13.	Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☒

Identification	
HEIGHT 5'10"	WEIGHT 155 lbs
COLOR OF EYES BROWN	COLOR OF HAIR BLACK

EDUCATION AND EXPERIENCE

Provide a chronological listing of your educational preparation and post-g[...] if necessary.)

7/10/97

Schools Attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Number of Years Attended	Dates Attended From (mo/yr)	Dates Attended To (mo/yr)	Diploma or Degree Obtained (Quote titles in original language and translate to English.)
Medical Education (List all Medical Schools Attended) UCLA	4	08/91	06/95	MD
—				
—				
Post-Graduate Training (List all Programs Attended) UNIVERSITY OF WASHINGTON MEDICAL CENTER	PRESENT	06/95	06/99	PURSUIT OF SPECIALTY OF OB/GYN
—				
—				

PROFESSIONAL EXPERIENCE

In chronological order list all professional experience received since graduation from medical school to the present. (Exclude activities listed under other sections. Identify any periods of time break of 30 days or more.) (Attach additional 8 1/2 X 11 inch sheets if necessary.)

Nature of Experience or Practice	Dates of Experience From (mo/yr)	Dates of Experience To (mo/yr)
NA		

HOSPITAL PRIVILEGES

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. (Attach additional 8 1/2 X 11 inch sheets if necessary.)

Name of Hospital (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	Dates	
	Beginning (mo/yr)	Ending (mo/yr)
NA		

LICENSES IN OTHER STATES

List all licenses to practice medicine in any state, Canadian province or other country. (Include whether active or inactive.)

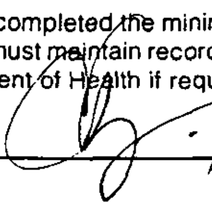
State, County or Province	Date License Issued	License Number	Basis of Licensure		Status of License Active or Inactive	Any Limitations on License
			Examination (Date Passed)	Endorsement		
NONE						

FIFTH PATHWAY (Foreign Trained Applicants only) (attach additional 8 1/2 X 11 inch sheets if necessary.)

Name and Location of Medical School	Name and Location of Hospital	Dates Attended	
		Beginning (mo/yr)	Ending (mo/yr)
NA			

AIDS Affidavit

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS. I understand I must maintain records documenting said education, for two (2) years and be prepared to submit those records to the Department of Health if requested. (WAC 246-919-380)



APPLICANT'S SIGNATURE

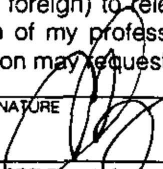
7/18/97
DATE

APPLICANT'S ATTESTATION

I, CHARLIE BROWNE, certify that I am the person described and identified in this application, that I have read 18.130.170 RCW and 18.130.180 RCW, of the Uniform Disciplinary Act, and that I have answered all questions in the application truthfully and completely and the documentation provided in support of the application is, to the best of my knowledge, accurate. I understand that the Department may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and Present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Commission any information, files or records required by the Commission for its evaluation of my professional, ethical and physical qualifications for licensure in the State of Washington. I understand the Commission may request a physical and mental evaluation to determine my fitness for practice.

APPLICANT'S SIGNATURE



DATE 7/18/97

DREW/UCLA MEDICAL EDUCATION PROGRAM
OFFICIAL TRANSCRIPT

RECEIVED
FEB 20 1996

Name : Browne, Charlie M.

S.S.N. 22 Licensee
D.O.B.: 1/10/63

Date Transcript Prepared: 2/13/96

First Year: 1991-1992

	UNITS	Grade		UNITS	Grade
Behavioral Sciences	5	B	Basic Neurology	6	B
Biomathematics	2	A	Biochemistry	5	B
Biomedical Ethics	1	A	Biochemistry Lab	3	A
Gross Anatomy	8	B	Interactive Teaching 3	2	A
Interactive Teaching 1	2	A	Interactive Teaching 4	2	A
Interactive Teaching 2	2	A	Physiology	8	B
Microscopic Anatomy	5	C	Social Medicine	1	P
Clinical Correlates					
				GPA	3.18

Second Year: 1992-1993

	UNITS	Grade		UNITS	Grade
Epidemiology	2	B	Clinical Pharmacology	1	C
General Pathology	8	B	Genetics	2	B
Interactive Teaching	2	A	Pathophysiology of Disease	12	B
Microbiology & Immunology	8	B	Psychopathology	3	A
Pharmacology	5	B			
Clinical Fundamentals	12	A		GPA	3.29

Third and Fourth Year Clinical Continuum (*Required Courses*) - 58 weeks

	UNITS	Grade		UNITS	Grade
Anesthesiology	2	B	Primary Care	16	B
ENT	2	A	Family Medicine	4	B
Psychiatry	6	A	Radiology	2	A
Medicine I	8	B	Surgery I	8	B
Medicine II	6	C	Surgery II	4	B
Obstetrics/Gynecology	8	A	Pediatrics	8	A
				GPA: 3.27	

Third and Fourth Year Clinical Continuum (*Electives*)

Course	Grade	Course	Grade
Research (in hypertension), Barbados 7/18-8/14/94	A	SU224 Breast Cancer Surgery,CHS 12/5-12/18/94	A
SU110 Fluids & Electrolytes, CHS 12/5-12/18/94	A	OG308 Obstetrics & Gynecology,KDMC 11/7-12/4/94	A
PE409 Pediatrics, Kaiser Sunset 1/2-1/29/95	A		
OG308 Ob/Gyn, KDMC 11/7-12/4/94	A		

GRADUATION DATE: 5/21/95

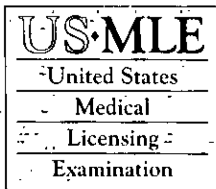
Drew /UCLA Medical Education Program
Charles R. Drew University of Medicine and Science
1621 East 120th Street
Los Angeles, CA 90059

CHARLES R.
DREW
UNIVERSITY OF MEDICINE & SCIENCE
1621 East 120th Street, Los Angeles, California 90059

MEDICAL STUDENT AFFAIRS
D04280

To: STATE OF WASHINGTON DEPARTMENT OF HEALTH
HEALTH PROFESSIONS SECTION FIVE
1300 SE QUINCE St, MS 7866
OLYMPIA, WA 98504-7866

OFFICIAL TRANSCRIPT ENCLOSED



United States Medical Licensing Examination™
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 07/30/1997

PROCESSED
AUG 04 1997
HEALTH PROFESSIONS
SECTION 5

Washington Medical Quality Assurance Commission
ATTN: Keith O Shafer, Exec Director
PO Box 47866
OLYMPIA, WA 98504-7866

Examinee: Browne, Charlie M
USMLE ID#: 4-022-177-2
DOB: 01 / 10 / 1963
Alt Name(s):

STEP1 The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.

Test Date	Pass/Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
6 /1993	PASS	194	176	80	75	

STEP2 The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.

Test Date	Pass/Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
3 /1995	PASS	187	167	79	75	
8 /1994	FAIL	166	167	74	75	

STEP3 The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.

State Board	Test Date	Pass/Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
WASHINGTON	5 /1996	PASS	189	176	78	75	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

See reverse side for explanation of information reported above.

Authenticity of USMLE™ Transcripts

Original, certified transcripts of United States Medical Licensing Examination (USMLE) scores are printed on blue safety paper and are produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The embossed USMLE seal in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history, and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For recent administrations, the mean and standard deviation of scores on the three-digit scale for first-time examinees from medical schools in the United States are approximately 205 and 20, respectively, and most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 82 on the two-digit scale is equivalent to a score of 200 on the three-digit scale. A score of 75 on the two-digit scale is always the minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each Step of USMLE is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 6 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

NOTATION REGARDING FSMB BOARD ACTION DATA BANK

The *Board Action Data Bank* of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. armed forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the *Bank*, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the *Board Action Data Bank* are not disciplinary or otherwise prejudicial in nature. Such actions are reported to assure records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Special circumstances in connection with the administration of an examination may result in one of the following annotations being listed next to the score for that examination:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

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

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. To obtain information regarding the nature of the irregular behavior, the full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

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

Testing Accommodations - Following review and approval of a request from the examinee, testing accommodations were provided in the administration of the examination.

977-5/97

Health

MD

TO: **Post-Graduate Training Program Director**

UNIVERSITY OF WASHINGTON
FACILITY NAME
BOX 356460, SEATTLE
ADDRESS
WA, 98112

PROCESSED
JUL 23 1997
HEALTH PROFESSIONS
SECTION 5

RE: Verification/Evaluation of Training

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

CHARLIE BROWNE
APPLICANT (PRINT OR TYPE)

01-10-63
BIRTHDATE

[signature]
SIGNATURE OF APPLICANT

1. Charlie Browne is or was engaged in post-graduate training in our program from 25 June 95 (BEGINNING DATE (MONTH & YEAR)) to present (ENDING DATE (MONTH & YEAR)), in the field of Ob-Gyn

2. **Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evaluations conducted.)** Dr Browne has performed satisfactorily as a resident in the University of Washington Ob-Gyn affiliated residency program. He is knowledgeable, conscientious & responds well to instruction.

3. **Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program?** ☐ Yes ☒ No If yes, please explain

4. **Is there anything in the participant's file which would indicate he/she would be unable to safely practice medicine?** ☐ Yes ☒ No If yes, please provide documentation.

5. We would appreciate any further documentation you feel would assist in the evaluation process. Thank you.

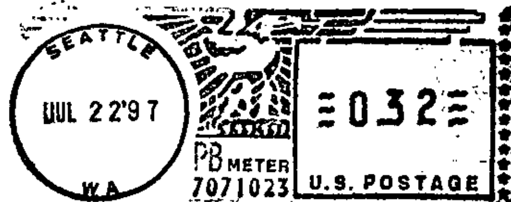
Return to:
Medical Quality Assurance Commission
1300 SE Quince Street
P O Box 47866
Olympia, WA 98504-7866
(360) 664-8689 or (360) 753-2844

(Seal)

Signature [signature]
Title Prof & Vice Chair
Hospital U of W
PLEASE TYPE OR PRINT
Address Dept Ob-Gyn 356460
Seattle Wa 98195
Date 21 July 97
Telephone (206) 543-3891

DOH 657-034 (Rev. 2/96)

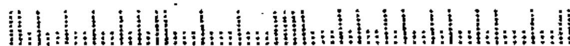
Office of the Dean
Housestaff Affairs Office
C-212 Health Sciences Bldg.
Box 356340
Seattle, WA 98195-6340



07-9675

Medical Quality Assurance
Commision
PO Box 1099
Olympia, WA 98507-1099

98507-1099



telnet (WA-RS6000-1)

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                           AAAAAA     SSSSSS    IIIIIIIIIII
                          AAAAAAA    SSS  SSS   IIIIIIIIIII
                         AAAAAAAA   SSS    SSS      III
MEDICAL BOARD                  ASSESSMENT SYSTEMS, INC.                 07-28-97
bje1303                              REAL SYSTEM           V2.5.14      10:45:22 AM
INDIVIDUAL NAME                          (JR,SR,III)        REFERENCE # ML20005045
   LAST BROWNE                                              SOC SEC NUM     -  -
  FIRST CHARLIE                         +-ADDITIONAL INFORMATION----------------+
 MIDDLE                                 |          SEX M =      MARRIED N =     |
                                        |                                       |
RESIDENCE INFORMATION                   |   OTHER NAME                          |
UNVIERSITY OF WASHINGTON                |CORP. OFFICER                        = |
DEPT OF OB/GYN BOX 356460               |TRUST ACCOUNT                          |
SEATTLE, WA 98195-6460                  |                                       |
                                        |  BIRTH PLACE BARBADOS                 |
                                        |         DATE 01-10-1963               |
PHONE: (   )    -      COUNTY:   17     |                                       |
       (   )    -      LGL ST: WA       |SCHOOL CODE 005.14                     |
                                        |   CE UNITS    0.00 REQD BY   -  -     |
NOTES                                   +---------------------------------------+
6/28/96 NEED RNWL $$ - HAVE RC MP\
+-------------------------------------------------------------------------------+
|CURRENT STATUS: E    EXPIRATION DATE: 07-31-1996  FIRST ISSUE DATE: 06-26-1995|
|RENEWAL STATUS: M   LAST ACTIVE DATE: 07-31-1996 LAST RENEWAL DATE: 06-26-1995|
|COMPLAINTS O/C:  0/ 0      AUTHORITY: RE                                       |
+-------------------------------------------------------------------------------+
1GO BACK  2NAM&ADDR 3EDUCATE  4LIC FUNC 5INVESTG  6         7OTHR DAT 8EXTD NOT
```

RECEIVED
JUL 24 1997
By______

TO THE APPLICANT

Complete the identifying information below and submit to:

Federation of State Medical Boards
400 Fuller Wiser Road
Euless, TX 76039-3855

Attention: Barbara Rains
Board Inquiry Specialist

PROCESSED
AUG 04 1997
SECTION 5

Department of Health
Medical Quality Assurance Commission
1300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504-7866

Date:

Dear Ms. Rains:

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

NAME: CHARLIE BROWNE

SSN: 22 Licensee SSN

MEDICAL SCHOOL OF GRADUATION: UCLA

YEAR OF GRADUATION: 1995

BIRTHDATE: 01-10-63

RESPONSE:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

JUL 30 1997

James R. Winn, M.D.
JAMES R. WINN, M.D
EXECUTIVE VICE-PRESIDENT

DOH 657-072 (Rev. 02/96))

American Medical Association

Physicians dedicated to the health of America

AMERICAN MEDICAL ASSOCIATION

Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

PROCESSED
AUG 20 1997
HEALTH PROFESSIONS
SECTION 5

Name and Address:

CHARLES M BROWNE MD
2319 E LYNN ST
SEATTLE WA 98115 USA

Phone: UNKNOWN
Birthdate: 01/10/1963
Birthplace: BRIDGETOWN

Physician's Major Professional Activity: RESIDENT

Self Designated Practice Specialties (SDPS):
Primary: OBSTETRICS AND GYNECOLOGY
Secondary: UNSPECIFIED

AMA membership: NOT A MEMBER

Following Data Provided by the Primary Sources

Medical School:
UNIV OF CA, LOS ANGELES, UCLA SCH OF MED, LOS ANGELES CA 90024 (VERIFIED)

Year of Graduation: 1995 (VERIFIED)

Current and/or Prior Medical Training or Fellowship:

Institution: UNIV OF WA SCH OF MED
RESIDENT
Specialty : OBSTETRICS AND GYNECOLOGY

State: WASHINGTON
(VERIFIED)
06/1995 - 06/1999

Note: **Additional information, used for appointments and privileges, is not solicited, nor is it received from the residency program directors. If additional information is required, please contact the program director(s).**

National Board Certification Year: NONE REPORTED TO DATE

License(s) : State	MD/ DO	Date Granted	Expiration Date	Status	License Type	As of

Note: **When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. A blank expiration date indicates that the data is not provided to AMA by the licensing board. Please contact the appropriate licensing board directly for this information.**

NONE REPORTED TO DATE

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It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency: **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited unless otherwise agreed to in writing by the AMA.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or , in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

American Medical Association

Physicians dedicated to the health of America

Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

Federal Drug Enforcement Administration:

TO DATE, FEDERAL DEA REGISTRATION STATUS IS UNKNOWN.

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

Specialty Board Certification(s):

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

Primary Board: NONE REPORTED TO DATE

Effective: **Expires:**

Subcertification or Certificate of Special Competence: NONE REPORTED TO DATE

Effective: **Expires:**

Note: For certfication dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY HCFA.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the Physician Profile is intended as an instrument to assist with credentialing. Appropriate use of the Physician Masterfile data contained on this profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations and the Utilization Review Accreditation Commission. The Physician Masterfile meets the National Committee for Quality Assurance Standards for verification of medical education, residency training and board certfication.

If you note any discrepancies, please mark them on a copy of the profile and return to: American Medical Association Department of Data Services, 515 N. State Street, Chicago, Il 60610.

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Board of Medical Examiners

Limited Physician Application Worksheet

NAME: Browne, Charlie

DATE OF BIRTH: 1-10-63

DATE APPLICATION RECEIVED: 5/5/95

DATE APPLICATION COMPLETED: ______

225 Fee | ✓ Photo | ✓ Personal Data | ✓ Aids | ✓ Affidavit

___ Residency | ___ Fellowship | ___ Teaching/Research | ___ Institutions | ___ City/County

Positive Data Questions ____ ____ ____   Documentation Received ______

✓ Chronology Completed   ____ Missing Dates ____ to ____ ____ to ____ ____ to ____

MALPRACTICE CASE	SYNOPSIS	ORIGINAL COMPLAINT	DISPOSITION
CASE 1 NAME:			
CASE 2 NAME:			

✓ FDB
☐ AMA
☐ ECFMG

Medical School ☒ U.S. ☐ Canadian ☐ International ☐ Fifth Pathway

MEDICAL SCHOOL NAME: UCLA   2/96 Transcript   ____ Translations   YEAR OF DEGREE: 1995

Examination Type ☐ National Board ☐ FLEX ☐ USMLE ☐ State Exam ☐ LMCC   Scores Received ____

POSTGRADUATE TRAINING PROGRAM

STATE LICENSURE

HOSPITAL PRIVILEGES

EMPLOYMENT/PROGRAM VERIFICATION

✓	Residency Cert.		

STAFF DECISION

☑ APPROVED
☐ DISAPPROVED

LICENSURE

SIGNATURE: Renee Weber   DATE: 2/22/96

COMMENTS:

BME 062 (REV. 8/12/93)

Return with check or money order to ensure proper credit of your examination fee.

DEPOSIT CREDIT

Limited Physician

CHARLIE BROWNE

NAME (Please Print)

DATE 4/1/95

DOH 657-081 (4/94)

Washington State Department of Health
P.O. Box 1099
Olympia, Washington 98507-1099

Check	Money Order
$ 225	

Please note amount enclosed, and return with your application.

1A 0252140000 00336

DATE	TELEPHONE LOG	INITIALS

Washington State Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

APPLICATION FOR LIMITED LICENSE TO PRACTICE MEDICINE
Applicable for MD's Only

FOR OFFICE USE ONLY		
CERTIFICATE NO. 5045	ISSUE DATE 6/26/95	EXPIRATION DATE 7/31/96

Limited license application is made in conjunction with employment in: (check one)

- ☐ Institutional
- ☐ Fellowship - 2 year limit
- ☐ County-City Health Department
- ☐ Internship-Residency
- ☐ Teaching-Research - 2 year limit

PLEASE TYPE OR PRINT CLEARLY

Applicant's Name BROWNE (LAST) CHARLIE (FIRST) (MIDDLE INITIAL)

Name of Institution/Health Dept/Medical School/Hospital UWMC - UNIVERSITY OF WASHINGTON MED CTR

Address DEPT OF OB-GYN, RH-20

City SEATTLE State WA ZIP 98195

Telephone No. (206) 543-9626
ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.

Social Security Number 22 Licensee SSN
REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND NOT REQUIRED FOR LICENSING APPROVAL.

Sex (F or M) M Birthdate 01 (MONTH) 10 (DAY) 63 (YEAR)

Birthplace BRIDGETOWN (CITY), (STATE) BARBADOS (COUNTRY)

Medical specialty OB-GYN

Medical School Attended UCLA (NAME/COUNTRY) Year of Graduation 1995

List other name(s) that may appear on documents or credentials —

Have you previously applied for a Washington State Medical License or limited license? ☐ Yes ☒ No

Follow carefully all instructions in general instructions - all applicants. It is the responsibility of the applicant to submit or request to have submitted, all required supporting documents.

PERSONAL DATA

	Question	Yes	No
1.	Have you ever had a license to practice medicine suspended, revoked, restricted or denied or voluntarily surrendered a physicians license in any state, federal or foreign jurisdiction?	☐	☑
2.	Have you ever had hospital privileges, or medical society membership revoked, suspended, restricted or denied on grounds of unprofessional conduct, incompetence, negligence, or unsafe practices?	☐	☑
3.	Have you ever been convicted of any gross misdemeanor or felony relating to the practice of medicine?	☐	☑
4.	Have you ever been ~~the recipient of any disciplinary action, including reprimand or have~~ you ever entered a stipulated agreement or agreed to discontinue an act alleged as a violation of law or an unsafe practice?	☐	☑
5.	Have you ever been notified that any information pertaining to you been submitted to the National Data Bank?	☐	☑
6.	Have you ever been denied a DEA registration number or been issued a restricted DEA registration or voluntarily surrendered a DEA registration?	☐	☑
7.	To the best of your knowledge, are you the subject of an investigation by any licensing board as of the date of this application?	☐	☑
8.	Have you ever agreed to restrict your practice in lieu of or to avoid formal action?	☐	☑

If response to 1-8 is affirmative, attach certified copies of orders, stipulations, agreements, charges, judgements sentences, findings and nature of decisions. If on parole or probation, include a letter from the supervising officer indicating progress.

	Question	Yes	No
9.	Have you ever been found guilty of the violation of any drug law, or prescribing controlled substances for yourself or been found guilty of a traffic citation involving drug or alcohol?	☐	☑
10.	Have you ever been involved in the possession, use, prescription for use, or diversion of controlled substances or legend drugs in any other way than for legitimate or therapeutic purposes?	☐	☑
11.	Have you ever submitted or been required to submit for treatment for alcohol dependency?	☐	☑

If response to 9 through 11 is affirmative, attach copies of charges, sentences, orders, stipulation and/or dispositions. Also include letters from the treating professional and/or institution stating details of condition or addiction, treatment and prognosis.

	Question	Yes	No
12.	Have you ever received treatment for a mental illness?	☐	☑
13.	Have you ever been released from or restricted in a medical program because of a mental condition or illness?	☐	☑
14	Are you currently afflicted with a mental or physical condition which impairs or restricts your ability to practice with reasonable skill and safety?	☐	☑

If response to 12 through 14 is affirmative, attach copies of letters from treating professional, program and/or institutions describing diagnosis, treatment and prognosis. This information is treated as confidential and exempt from public disclosure unless formal disciplinary action is taken against your application on the basis of a mental or physical condition impairing your ability to practice with reasonable skill and safety.

	Question	Yes	No
15.	Have you been named in any malpractice suits alleging your incompetence or negligence in the practice of medicine? If yes, include the nature of the case, date, and summarize care given. Enclose a copy of the original complaint and settlement or final disposition. If pending, indicate the status.	☐	☑

Failure To Give Complete And True Information Constitutes Cause For Denial
Of Your Application For Licensure
RCW 18.130.180(2)

IDENTIFICATION

HEIGHT 5'10"	WEIGHT 145
COLOR OF EYES BLACK	COLOR OF HAIR BLACK

1. Ori
2. No
3. Tal
4. Clo
5. Ins

EDUCATION AND EXPERIENCE

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training.

(Attach additional 8 1/2 x 11 sheet if necessary)

SCHOOLS ATTENDED-LOCATION IF OTHER THAN U.S., QUOTE NAMES OF SCHOOLS IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH.	NUMBER OF YEARS ATTENDED	ATTENDANCE ENTRANCE DATE MO./YR.	ATTENDANCE LEAVING DATE MO./YR.	DIPLOMA OR DEGREE OBTAINED QUOTE TITLES IN ORIGINAL LANGUAGE AND TRANSLATE TO ENGLISH
Medical Education (List all Medical Schools Attended)				
UCLA	4	8/91	6/95	M.D.
Post-Graduate Training (List all programs attended)				

In Chronological Order List All Professional Experience Received Since Graduation From Medical School To The Present.
(Exclude Activities Listed Under Other Sections.) (Identify Any Periods Of Time Break Of 30 Days or More.) (Attach additional 8 1/2 x 11 sheet if necessary)

INDICATE NATURE OF EXPERIENCE OR PRACTICE	INCLUSIVE DATES OF EXPERIENCE BEGINNING MO./YR.	ENDING MO./YR.

Please list hospitals in the US or Canada where privileges have been granted within the past five (5) years. (Attach additional 8 1/2 x 11 sheet if necessary)

(FOR LOCUM TENENS, ENTER ONLY THOSE OF A 30 DAY OR LONGER DURATION. SEE INSTRUCTIONS REGARDING REPORTS AND VERIFICATION.)	BEGINNING DATE	ENDING DATE

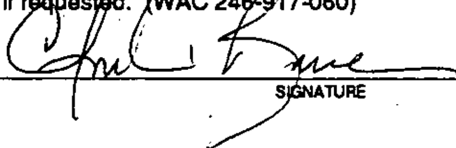
LICENSES IN OTHER STATES/COUNTRIES

List all licenses to practice medicine in any state, Canadian province or other country. (Include whether active or inactive.)

STATE, COUNTRY OR PROVINCE	DATE LICENSE ISSUED	NUMBER	BASIS OF LICENSURE		STATUS OF LICENSE ACTIVE/ INACTIVE)	ANY LIMITATIONS ON LICENSE
			EXAMINATION (DATE PASSED)	ENDORSEMENT		

AID'S AFFIDAVIT

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS. I understand I must maintain records documenting said education, for two (2) years and be prepared to submit those records to the Department if requested. (WAC 246-917-060)



SIGNATURE

4/1/95

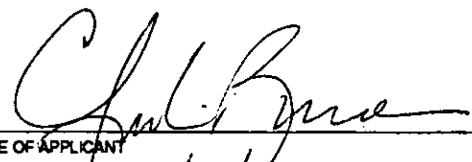
DATE

APPLICANT'S ATTESTATION

I, CHARLIE BROWNE, state that I am the person described and identified in this
(PRINT OR TYPE FULL NAME OF APPLICANT)

application, that I have read 18.130.170 RCW and 18.130.180 RCW of the Uniform Disciplinary Act, and that I have answered all questions in this application truthfully and completely and the documentation provided in support of the application is, to the best of my knowledge, accurate. I understand that the Department may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files or records required by the Board for its evaluation of my professional, ethical and physical qualifications for licensure in the State of Washington. I understand the Board may request a physical or mental evaluation to determine my fitness for practice.



SIGNATURE OF APPLICANT

4/1/95

DATE

MAY 18 1995
DEPT OF HEALTH

TO THE APPLICANT

Complete the identifying information below and submit to:

Federation of State Medical Boards
6000 Western Place, Suite 707
Fort Worth, Texas 76107

Attention: Barbara Rains
Board Inquiry Specialist

Department of Health
Board of Medical Examiners
1300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504-7866

MAY 10 1995

Date:

Dear Ms. Rains:

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

NAME: CHARLIE BROWNE

SSN: 22 Licensee SSN

MEDICAL SCHOOL OF GRADUATION: UCLA

YEAR OF GRADUATION: 1995

BIRTHDATE: 01-10-63

RESPONSE:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAY 16 1995

James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

CK

DOH 657-072 (Rev. 02/92))

CA 3860

4

-2205

Board of Medical Examiners

Residency Certification

This is to certify that CHARLIE BROWNE has been

appointed as a resident* in OB-GYN (SERVICE) at

the UWMC University of Washington Affiliated hospital for the period

beginning 06 (MONTH) 26 (DAY) 95 (YEAR). The individual responsible for this resident's patient care activities

will be [signature] (SIGNATURE) DIRECTOR OF PROGRAM.

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

(Hospital Seal)

DOH 657-057 (Rev. 3/91)

- Board of Osteopathic Medicine & Surgery
- Certified Respiratory Care Practitioners
- Health Care Assistants
- Medical Quality Assurance Commission
- Podiatric Medical Board
- Radiologic Technology Program

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

HEALTH PROFESSIONS SECTION FIVE

1300 SE Quince St, MS 7866 • Olympia, WA 98504-7866

December 29, 1995

Charlie Browne, MD
University of Washington
Dept. of OB/GYN, RG-20
Seattle, WA 98195

Dear Dr. Browne:

As of this date, our records indicate the following items still have not been received. In order for us to continue processing your application we will need the following documents:

Medical School Transcripts

Upon receipt of the above mentioned items, your application will be considered complete and will begin the review process.

If you have any questions, please contact me at (360) 753-2844.

Sincerely,

Carolynn Bradley

Carolynn Bradley
Program Representative

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
1300 SE Quince St • P.O. Box 47866 • Olympia, WA 98504-7866

August 14, 1997

Charlie Browne, MD
2319 E Lynn
Seattle, WA 98112

Dear Dr Browne

As of this date, our records indicate the following items still have not been received. In order for us to continue processing your application we will need the following documents:

American Medical Association

Upon receipt of the above mentioned items, your application will be considered complete and will begin the review process.

If you have any questions, please contact me at (360) 753-2844.

Sincerely,

Betty Elliott
Program Reprsentative

UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

7/21/97

Please pull transcripts from limited file # 5045. Also - check inclosed to renew limited license for 7-1-96 to 7-31-97. Thanks.

Betty - I have this. Marie

Libby Sando
Coordinator
Housestaff Affairs
Graduate Medical Education Programs
Office of the Dean
C212 Health Sciences Center
Box 356340
Seattle, WA 98195-6340
Phone: (206) 543-0065
Fax: (206) 685-3314
libby@u.washington.edu

Redaction Date: 4/26/2021 1:38:06 PM

Redaction Log

Total Number of Redactions in Document: 5

Redaction Reasons by Page

Page	Reason	Description	Occurrences
4	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1
8	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1
15	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1
23	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1
27	22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	1

Redaction Date: 4/26/2021 1:38:06 PM

Redaction Log

Redaction Reasons by Exemption

Reason	Description	Pages (Count)
22 Licensee SSN	RCW 42.56.350(1): Health professionals. (1) The federal social security number of individuals governed under chapter 18.130 RCW maintained in the files of the department of health is exempt from disclosure under this chapter	4(1) 8(1) 15(1) 23(1) 27(1)