ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

Are you utilizing FCVS for your Arkansas license? ☑ Yes ☐ No
Are you a current or former member of the U.S. military or a spouse of a current or former member of the U.S. military? ☐ Yes ☑ No

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS
& Centralized Credentials Verification Service

1. Please read the IMPORTANT INFORMATION and ALL INSTRUCTIONS included in the application packet.
2. Type or print legibly (in dark blue or black ink) all application documents. (One sided documents only.)
3. Provide exact dates whenever possible, in *mm/dd/yyyy* format.
4. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.
5. Give careful thought to each answer because you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Parts IV or V of the application, you MUST submit a signed and dated explanation.
7. Failure to answer all questions completely and accurately; omitting or falsifying information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. *When in doubt, disclose and explain all information.*

TYPE OF LICENSE YOU ARE APPLYING FOR (check one)

☒ Medicine/Surgery (MD) ☐ Osteopathic Medicine/Surgery (DO) ☐ Educational License

Are you requesting that a temporary license be issued prior to full licensure? ☐ Yes ☒ Not at this time

PART I - PERSONAL IDENTIFICATION INFORMATION

1a. Full Legal Name (Last, First, Middle, Suffix, Degree)
Phifer **Jamie** **Michele** **MD**

1b. Other Names Used (including Maiden Name)

2a. Social Security Number	2b. Driver's License State & Number	2c. Gender	2d. Date of Birth (mm/dd/yyyy)
	WA	☐ Male ☒ Female	

3a. Place of Birth	3b. Country of Citizenship
Atlanta **GA**	**USA**
3c. Immigration Status (if not U.S. citizen)	3d. How long have you been in the U.S.? (if not U.S. citizen)
U.S. Citizen (Birth/Naturalization)	
3e. Ethnicity ☒ Non-Hispanic ☐ Hispanic	3f. Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☒ White ☐ Hawaiian/Pacific Islander ☐ Hispanic

4a. Public Address (Street, City, State, Zip Code)
701 5th Ave, Ste 2300, Seattle, WA 98104

4b. Private Address (Street or PO Box, City, State, Zip Code)

4c. Private Phone #	4d. Work Phone #	4e. Fax #	4f. Mobile Phone #
	866-657-7991	**206-701-9452**	

4g. Personal E-mail Address	5a. If not currently living in Arkansas, do you plan to relocate?
	☒ No ☐ Yes - Approx. date: _____

5b. Intended Practice Location in Arkansas: Name and Address of Hospital, Clinic, Group or Private Practice
98point6 **701 5th Ave, Ste 2300, Seattle, WA 98104**

5c. Will you be providing telemedicine services from outside the state of Arkansas?
☐ No ☒ Yes - Name of Telemedicine Contract Firm: 98point6 (Seattle, WA) Phone 866-657-7991

6a. NPI Number	6b. Accept Medicaid/Medicare Patients?
	☐ Medicare ☐ Medicaid ☒ Neither ☐ Unknown/Undecided

FOR ASMB USE ONLY

Name Jamie, Michele, Phifer, M.D. Application Received 11/13/19
License Number _____ Fees Received $500.00
License Issued _____ Application Declined _____
Basis for License USMLE PHIDNo. ASMB2.16554

PART II - EDUCATION

MEDICAL SCHOOL EDUCATION

List all medical school(s) you attended (attach additional sheets if necessary). If you attended more than one medical school, provide the reason you changed medical schools on a separate sheet of paper, signed and dated by you. If you completed medical school in more or less than four years, provide the reason on a separate sheet of paper, signed and dated by you.

7a. Institution Name: University of Florida College of Medicine

7b. Country of Medical School: USA

7c. Mailing Address (Street Address, City, State/Country, Zip Code): 1600 SW Archer Rd # M509, Gainesville, FL 32610

7d. Start Date	7e. End Date	7f. Graduated?	7g. Degree Awarded
08 /13 /2007	05 /15 /2011	[X] Yes [ ] No	[x] M.D. (or foreign equivalent) [ ] D.O. [ ] None

8a. Institution Name:

8b. Country of Medical School:

8c. Mailing Address (Street Address, City, State/Country, Zip Code):

8d. Start Date	8e. End Date	8f. Graduated?	8g. Degree Awarded
/ /	/ /	[ ] Yes [ ] No	[ ] M.D. (or foreign equivalent) [ ] D.O. [ ] None

POSTGRADUATE EDUCATION, US OR FOREIGN

List internships, residencies, fellowships and other postgraduate training chronologically (attach additional sheets if necessary). If you did not complete a program or changed schools between years, provide the reason on a separate sheet of paper, signed and dated by you. If program still in process, enter anticipated completion date as end date.

9a. Full Name of Training Program: Swedish Cherry Hill Family Medicine Residency

9b. Program ID (if known):

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name
Residency	Family Medicine	Family Medicine

9f. Mailing Address (Street Address, City, State/Country, Zip Code): 550 16th Ave, Suite 400, Seattle, WA 98122

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
06 /21 /2011	06 /24 /2014	/ /	[x] Yes [ ] No [ ] In Process	[ ] Yes [x] No

9a. Full Name of Training Program:

9b. Program ID (if known):

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name

9f. Mailing Address (Street Address, City, State/Country, Zip Code):

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
/ /	/ /	/ /	[ ] Yes [ ] No [ ] In Process	[ ] Yes [ ] No

9a. Full Name of Training Program:

9b. Program ID (if known):

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name

9f. Mailing Address (Street Address, City, State/Country, Zip Code):

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
/ /	/ /	/ /	[ ] Yes [ ] No [ ] In Process	[ ] Yes [ ] No

9a. Full Name of Training Program:

9b. Program ID (if known):

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name

9f. Mailing Address (Street Address, City, State/Country, Zip Code):

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
/ /	/ /	/ /	[ ] Yes [ ] No [ ] In Process	[ ] Yes [ ] No

EXAMINATION HISTORY

Please specify exam series USMLE, NBME, FLEX, NBOME, COMLEX, LMCC (or State Exam prior to 1975). *If you failed any step of any examination, even once, you must submit a separate, signed and dated explanation of the circumstances.* Attach additional sheets if necessary.

10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED
USMLE Step 1	**1**	**0**	**06 / 30 / 2009**
10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED
USMLE Step 2 CK	**1**	**0**	**07 / 28 / 2010**
10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED
USMLE Step 2 CS	**1**	**0**	**09 / 03 / 2010**
10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED
USMLE Step 3	**1**	**0**	**05 / 07 / 2013**

10e. Have you ever taken the SPEX or COMVEX examination? ☐ Yes ☒ No If Yes, you must provide a signed and dated explanation.

11a. If you are an International medical graduate, do you hold an ECFMG certification? ☐ Yes ☒ No ☐ N/A (If No, you must provide a signed and dated explanation)	11b. ECFMG Certificate No.	11c. Date Issued
		/ /

SPECIALTY/ BOARD CERTIFICATION

Please list all specialties, including self-designated. Attach additional sheets if necessary.

12a. Primary Practice Specialty/Subspecialty	12b. Board Certified?	12c. Certification Type	
Family Medicine	☒ Yes ☐ No	☐ Lifetime ☒ Time-Limited ☐ MOC	
12d. Name of Specialty Board, if certified	12e. Certification Date	12f. Recertification Date	12g. Expiration Date
American Board of Family Medicine	**06 /25 / 2014**	/ /	**06 /25 /2024**
13a. Secondary Specialty/Subspecialty	13b. Board Certified?	13c. Certification Type	
	☐ Yes ☐ No	☐ Lifetime ☐ Time-Limited ☐ MOC	
13d. Name of Specialty Board, if certified	13e. Certification Date	13f. Recertification Date	13g. Expiration Date
	/ /	/ /	/ /
14a. Tertiary Specialty/Subspecialty	14b. Board Certified?	14c. Certification Type	
	☐ Yes ☐ No	☐ Lifetime ☐ Time-Limited ☐ MOC	
14d. Name of Specialty Board, if certified	14e. Certification Date	14f. Recertification Date	14g. Expiration Date
	/ /	/ /	/ /

PART III - PROFESSIONAL ACTIVITIES

PROFESSIONAL LICENSURE

List all states or territories of the United States or other countries in which you **hold or have ever held** a medical license. Include all temporary, instructional and training permits/licenses. Attach additional sheets if necessary. If none, enter "N/A."

15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
WA	**MD60359609**	**07 / 05 / 2013**	**08 / 25 / 2020**	**Active**
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
FL	**ME125540**	**09 / 08 / 2015**	**01 / 31 / 2020**	**Active**
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
IL	**036150427**	**08 / 07 / 2019**	**07 / 31 / 2020**	**Active**
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
KS	**04-40305**	**08 / 11 / 2017**	**07 / 31 / 2018**	**Expired**
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
MA	**281320**	**09 / 26 / 2019**	**08 / 25 / 2020**	**Active**
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
MD	**D87604**	**05 / 30 / 2019**	**09 / 30 / 2021**	**Active**
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
NJ	**25MA10601400**	**05 / 21 / 2019**	**06 / 30 / 2021**	**Active**
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
		/ /	/ /	

MILITARY SERVICE	Submit a copy of your separation papers (DD Form 214) with your application. If Active Duty, have the Verification of Current Military Service sent to this office or have your current Commanding Officer submit a verification letter directly to this office.

16a. Have you ever been in the armed forces? ☐ Yes ☒ No

16b. Country & Branch of Service	16c. Date of Entry	16d. Date of Discharge	16e. Type of Discharge
	/ /	/ /	
	/ /	/ /	

WORK HISTORY

Please provide a chronological listing for all medical and non-medical work history and other activities, including hospitals, faculty appointments, private practice, employment corporations, military assignments, government agencies, locum tenens and telemedicine assignments, and leaves of absence since graduation from medical school. Do not include Medical School or Postgraduate Education/Training. **Do not write, "See CV;" you must complete this section AND attach your curriculum vitae. If none, enter "N/A."**

17a. Date From 09 /13 /2019	17b. Date To Present	17c. Type of Affiliation, (Primary or Previous Practice, Employment, Staff Appointment, etc.) **Employment**
17d. Name of Institution/Facility **98point6** Practice		☒ Primary Practice ☐ Previous
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code) **701 5th Ave, Ste 2300, Seattle, WA 98104**		
17f. Title/Position/Staff Category **Telemedicine Physician**		17g. Specialty practiced or granted privileges in **Family Medicine**
17a. Date From 08 /26 /2014	17b. Date To Present	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.) **Employment**
17d. Name of Institution/Facility **Swedish Medical Group**		☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code) **600 University St #1200, Seattle, WA 98101**		
17f. Title/Position/Staff Category **Primary & Urgent Care Physician**		17g. Specialty practiced or granted privileges in **Family Medicine**
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in

WORK HISTORY, continued

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

FEDERAL DEA & STATE-ISSUED CONTROLLED SUBSTANCE REGISTRATIONS

List all current and previous Federal DEA and state-issued controlled substance registrations. If none, enter N/A.

18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date
	WA	600 University St #1200, Seattle, WA 98101	03 / 31 / 2021
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /

TIME GAPS

Please provide an explanation for ALL time gaps of 30 days or more since the start of medical school. If none, enter N/A.

19a. Did you have a time gap in excess of 30 days between medical school and post-graduate training? ☐ Yes ☒ No	19b. Dates of time gap

19c. Explanation for time gap: (e.g. traveling, vacation, moving, prepared for residency)

19d. Additional time gap. Provide dates and explanation.

Looking for employment post-residency (06/25/2014 - 08/25/2014)

19e. Additional time gap. Provide dates and explanation. Use additional sheets if necessary.

MALPRACTICE CLAIMS

List **all** malpractice claims ever filed against you, regardless of disposition. If none, enter "n/a". Use additional sheets if necessary.

20a. Date of Claim	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid
/ /		N/A	$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

PART IV - ATTESTATION QUESTIONS

21. Do you currently maintain individual or group Professional Liability Insurance (malpractice) coverage? ☐ No ☒ Yes
If no, list reason: _____
Insurance Carrier Name: _____
Policy Number(s): _____
Expiration Date: _____ Coverage Amounts: _____
If Group policy, list group name: _____

SPECIAL INSTRUCTIONS FOR QUESTIONS 22-44

- **Please mark the appropriate box next to each question. Do not leave any questions blank.**
- For each "Yes" response to questions 22-44, you must provide a separate, signed and dated statement giving full details including date, location, type of action, organization or parties involved, and specific circumstances. If you are not sure about how to respond to a question, it is best to disclose and provide an explanation.
- **Failure to answer these questions accurately may result in disciplinary action or denial of license application.**
- Confidentiality: The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

22.	Has your application for examination or licensure ever been rejected, denied or withdrawn? *If yes, explain.*	☒ No ☐ Yes
23.	Has any medical licensing board ever placed your license on probation, suspension, or has it revoked a license or certificate it had granted you? *If yes, explain and provide name and address of Board.*	☒ No ☐ Yes
24.	Have you ever been ordered to appear before a state medical board for any reason other than licensure? *If yes, explain.*	☒ No ☐ Yes
25.	Has a medical board or hospital ever initiated disciplinary procedures against you? *If yes, explain.*	☒ No ☐ Yes
26.	Have your privileges at any hospital ever been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? *If yes, explain.*	☒ No ☐ Yes
27.	Have you ever voluntarily surrendered your medical license in any state? *If yes, explain.*	☒ No ☐ Yes
28.	Since the start of medical school, have you been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony (including DWI (Driving While Intoxicated) or DUI (Driving Under the Influence)? (NOTE: ***You must answer "Yes" even if records, charges, or convictions have been pardoned, expunged, plead down, released, or sealed.***) *If yes, explain.*	☒ No ☐ Yes ☐ ☐
29.	Have you ever been denied provider participation in any state or federal Medicaid program? *If yes, explain.*	☒ No ☐ Yes
30.	Have you ever been warned, censured by, or requested to withdraw from any hospital in which you have been trained, been a staff member, or held hospital privileges? *If yes, explain.*	☒ No ☐ Yes
31.	Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency, or fellowship program? *If yes, explain.*	☒ No ☐ Yes
32.	Have you ever voluntarily or involuntarily left a training institution program before completing it? *If yes, explain.*	☒ No ☐ Yes

PART IV - ATTESTATION QUESTIONS, continued

33.	Have you ever been reported to the National Practitioner Data Bank or subject to NPDB adverse action reporting? *If yes, explain.*	[x] No [ ] Yes
34.	Have you ever resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted? *If yes, explain.*	[x] No [ ] Yes
35.	Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending? *If yes, explain.*	[x] No [ ] Yes
36.	Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicare/Medicaid program? *If yes, explain.*	[x] No [ ] Yes
37.	Have you ever been cited by a peer review organization? *If yes, explain.*	[x] No [ ] Yes
38.	Have you ever had to discontinue practice for any reason for a period longer than one (1) month? *If yes, explain.*	[x] No [ ] Yes
39.	Since the age of 21, have you been, or are you currently, being treated for alcoholism or substance abuse in an inpatient or outpatient setting? *If yes, explain.*	[x] No [ ] Yes
	39a. If Yes, was this the result of a medical board action?	[ ] No [ ] Yes
40.	Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine or to perform professional or medical staff duties in a competent, ethical, and profession manner? *If yes, explain.*	[x] No [ ] Yes
41.	Are you currently being, or have you ever been monitored by a Physicians Health Committee in any state? *If yes, explain, and ask the Physician Health Committee to send documentation of your status.*	[x] No [ ] Yes
42.	Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? *If yes, explain.*	[x] No [ ] Yes
43.	Have you ever defaulted on any Health Education Assistance loan? *If yes, explain.*	[x] No [ ] Yes
44.	To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? *If yes, explain.* **If, during the application process, you become aaware of any such investigation, you are required to report it to this office.**	[x] No [ ] Yes

PART V - AFFIDAVIT OF APPLICANT

I, the undersigned applicant, after being duly sworn, hereby certify that I have read the complete application and know the full content thereof. I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true, correct, current, and complete to the best of my knowledge. I attest that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy, and that said degree was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware. I certify that the photograph that appears below is a true likeness of me, taken within the past sixty (60) days. I understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, even if submitted separately, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice medicine in the State of Arkansas.

Jennie Chin
Applicant's Signature (in ink)
(must be signed in the presence of a Notary Public)

11/7/19
Date Signed
(must include the month, day and year signed)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the State of Washington, this 7 day of November, 20 19.
(Notary date must be the same as the applicant's signature date above)

Sydney D Carson
Notary Public
State of Washington
Commission Number 204409
My Commission Expires
December 21, 2022

My commission expires: 12-21-22

Sydney D Carson
Notary Signature
(Notary seal must be below the photograph at left)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Arkansas State Medical Board	As of Date:11/15/2019
Practitioner Name:	Phifer, Jamie Michele	

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Family Medicine
Certificate:	Family Medicine
Certification Type:	General
Certification Status:	Certified
Participating in MOC:	Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	06/25/2014		02/15/2020	Initial	10/31/2019

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution

Please note If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover

If your office also processes transcript requests, please attach the individual's official transcript

(which indicates courses taken, dates and hours of attendance, and scores, grades or evaluation)

Institution Name: University of Florida College of Medicine

Address Line 1:
University of Florida College of Medicine

Address Line 2:
PO Box 100216

City: Gainesville **State/Province:** FL **Zip Code (Postal Code):** 326100216

Country: US

If name of institution was different when this individual attended please note this name below

Premedical Education:

Years of education required for admission to your medical school 4

Credential/degree presented by the applicant for admission to your medical school BS Micro + Cell Science

Enrollment and Participation: Our records indicate that Phifer, Jamie Michele
(Name of individual's name Last First Middle Suffix)

attended our medical school for total of 164 weeks of medical education on the following dates **From:** 08.20.07 (Month Day Year) **To:** 05.13.11 (Month Day Year)

This individual

Was awarded the degree of MD. on 05.14.11 (Month Day Year)

Was NOT awarded a degree because: (please explain - additional page if necessary)

SEAL VERIFIED

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized

Watermark
(For FCVS internal use only)

Name: Julia Gilder

Signature: Julia Gilder

Title: Assistant University Registrar

ENTERED NOV 18 2019

Date of Signature: 11.20.18 Phone: 352 273 7978

Fax: 352 273 7536 Email: jgilder@ufl.edu

218298255 715 985 155 2256 218298255

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? ___ YES ✓ NO

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

Personal/Family	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Academic remediation	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Health	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Financial	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in joint degree Program (e.g., MD/PhD)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-degree research	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Other	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? ___ YES ✓ NO

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report

Academic Probation	From (Mo/Yr)___/___	To (Mo/Yr)___/___
Probation for unprofessional conduct/behavioral	From (Mo/Yr)___/___	To (Mo/Yr)___/___
Probation for other reason	From (Mo/Yr)___/___	To (Mo/Yr)___/___

Please specify a reason.

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? ___ YES ✓ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s)

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? ___ YES ✓ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

___ YES ✓ NO

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

If YES please provide detailed documentation/information about the nature of the limitations or special requirements

400 FULLER WISER ROAD | SUITE 300 | EULESS TX 76039 TEL:817.868.5000 FAX:817.868.5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Medical School

Medical Professional Name: Phifer, Jamie Michele

University of Florida College of Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Phifer, Jamie Michele

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

The University of Florida

has conferred on

Jamie Michele Phifer

the degree

Doctor of Medicine

and all the rights and privileges thereunto appertaining.
In Witness Whereof, this diploma, duly signed, has been issued
and the seal of the University affixed.

Issued by the Board of Trustees upon recommendation of the Faculty of

The College of Medicine

at Gainesville, this fourteenth day of May, 2011.

SEAL VERIFIED

Julian Gilder, Assistant University Registrar
College of Medicine University of Florida
November 20, 2018

I certify that this is a true and correct copy of the diploma presented to Jamie Michele Phifer at the University of Florida College of Medicine on May 14, 2011.

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5099 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: Swedish Medical Center/Cherry Hill Program
Specialty: Family Medicine
Address: Seattle, WA

Attention: Program Director
Affiliated University: University of Washington

Verification For:

Name: Jamie Michele Phifer

Individual's Name on Record (if different from above): _____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1
☑ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicne Residency - Cherry Hill
From: 06/23/11 To: 06/24/12
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 2
☐ Internship ☑ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine Residency - Cherry Hill
From: 06/25/12 To: 06/24/13
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 3
☐ Internship ☑ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine Residency - Cherry Hill
From: 06/25/13 To: 06/24/14
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

ELECTRONIC SEAL VERIFIED

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☑ No
2. Was this individual ever placed on probation? ☐ Yes ☑ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☑ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☑ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☑ No

Please explain any "Yes" response from above:

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Louis Paul Gianutsos, MD, MPH Signature: _____
Title: Program Director Date of Signature: 04/08/19
Tel: 206-320-4036 Fax: 206-320-8173 E-Mail: paul.gianutsos@swedish.org

Rev. 10/02/2018 FID: 215785155 ACGME ID: 1205421328 GME CODE: _____

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Phifer, Jamie Michele
Accreditation ID:	1205421328
Institution:	Swedish Medical Center/Cherry Hill Program
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 6/21/2011 - 6/21/2014 **Internship/Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Phifer, Jamie Michele

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

Swedish Medical Center

Cherry Hill

Seattle, Washington

This Certifies That

Jamie M. Phifer, M.D.

has faithfully and satisfactorily performed the duties of

Family Medicine Resident

from

June 21, 2011 to June 24, 2014

In witness whereof, the undersigned have affixed their signatures

Chief Executive

Professor and Chair, Department of Family Medicine
University of Washington School of Medicine

Administrative Director
Medical Education and Medical Staff Services

Director, Family Medicine Residency

SWEDISH MEDICAL CENTER INCORPORATED SEAL 1908 SEATTLE WASH.

UNIVERSITY OF WASHINGTON LVX SIT 1861

An Approved Residency in Family Medicine
Affiliated with the University of Washington School of Medicine

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board As of Date:11/15/2019

PRACTITIONER INFORMATION

Name:	Phifer, Jamie Michele
Medical School:	University of Florida College of Medicine Gainesville, Florida, UNITED STATES
Year of Grad:	2011
Degree Type:	MD

BOARD ACTIONS

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

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
	Individual			10/25/2019

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Reported
FLORIDA	ME125540	09/08/2015	01/31/2020	11/15/2019
ILLINOIS	036150427	08/07/2019	07/31/2020	08/28/2019
KANSAS	04-40305	08/11/2017	07/31/2018	11/05/2019
MARYLAND	D87604	05/30/2019	09/30/2021	11/15/2019
MASSACHUSETTS	281320	09/26/2019	08/25/2020	10/23/2019
NEW JERSEY	25MA10601400	05/21/2019	06/30/2021	11/01/2019
NEW YORK	301876	11/06/2019	10/31/2021	11/13/2019
OHIO	APP-000306301			11/15/2019
WASHINGTON	ML60224778	06/14/2011	07/05/2013	10/31/2019
WASHINGTON	MD60359609	07/05/2013	08/25/2020	10/31/2019

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board As of Date:11/15/2019

Practitioner Name: Phifer, Jamie Michele

US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
	22N 33N 4 5	JACKSONVILLE, FL 32216	03/31/2022	10/15/2019
.	22N 33N 4 5	SEATTLE, WA 98121	03/31/2021	10/15/2019

October 11, 2019

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

RE: License Certification for Jamie Michele Phifer

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Medical Doctor
LICENSE NUMBER:	ME125540
ORIGINAL CERTIFICATION:	09/08/2015
EXPIRATION DATE:	01/31/2020
CURRENT STATUS OF LICENSE:	CLEAR, ACTIVE
AGENCY ACTION:	None

This license information was last updated on: 10/11/2019

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595.

GREAT SEAL OF THE STATE OF FLORIDA · IN GOD WE TRUST ·

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NOV 1 2019

Florida Department of Health
Division of Medical Quality Assurance
4052 Bald Cypress Way, Bin C-10 / Tallahassee, FL 32399
PHONE: 850/488-0595 / FAX: 850/487-9626
FloridaHealth.gov

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Deborah Hagan
Secretary

Cecilia Abundis
Acting Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

1037 NE 65th St # 371
Seattle, WA 98115

Licensee: License	Jamie Phifer MD
Number:	036.150427
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	08/07/2019
Expiration Date:	07/31/2020
License Status:	ACTIVE
License Method:	ENDORSEMENT
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 10/11/2019

Cecilia Abundis
Acting Director
Division of Professional Regulation

10/11/2019
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

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NOV 18 2019

Facebook www.idfpr.com YouTube Twitter

Kansas State Board of Healing Arts
800 SW Jackson, Suite A-Lower Level
Topeka, KS 66612

Phone: 785-296-7413
1-888-886-7205
Fax: 785-296-0852
www.ksbha.org

Kathleen Selzler Lippert
Executive Director

Sam Brownback, Governor

October 11, 2019

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

This is to certify that: Jamie Michele Phifer has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number:	04-40305
Profession:	Medical Doctor (MD)
License Status:	Cancelled - Failure to Renew
Original License Date:	08/11/2017
License Cancellation Date:	07/31/2018
Disciplinary Action:	None

This license information was last updated on: 10/10/2019

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Verified by:

Nichole Schlesener
Licensing Manager/Administrator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612
785-296-1386 (phone)

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NOV 2019

MARYLAND
Department of Health Board of Physicians

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

October 14, 2019

Arkansas State Medical Board
1401 West Capitol Ave
Suite 340
Little Rock AR 72201

This is to verify the records of the Maryland Board of Physicians. The following information is available under the Maryland Public Information Act, State Government Article, Section 4-333, regarding the following practitioner:

Jamie Michele Phifer

For the Practice of:	Physician-M.D.
License Number:	D87604
Date Issued:	**05/30/2019**
Current Status:	**Active**
Expiration Date	**09/30/2021**
*Disciplinary Actions	**No disciplinary actions.**

*Disciplinary information can be found on our website. Go to https://www.mbp.state.md.us and select Lookup a License.

For malpractice claim information, please contact the Maryland Health Care Alternative Dispute Resolution Office 410.767.8200.

Respectfully,

Maryland Board of Physicians
Verification Unit

STATE OF MARYLAND BOARD OF PHYSICIANS

ENTERED NOV 18 2019

MISC

Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

www.mass.gov/massmedboard

Enforcement Division	Fax: (781) 876-8381
Legal Division	Fax: (781) 876-8380
Licensing Division	Fax: (781) 876-8383

10/16/2019

To Whom It May Concern:

This certifies that Jamie M Phifer, M.D., a 2011 graduate of University of Florida College of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 281320 was issued to Dr. Phifer on 09/26/2019. The license status is: Active. The expiration date is 8/25/2020.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

Closed Complaint Information

Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website:

www.mass.gov/massmedboard

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

ENTERED NOV 2019

SEAL

Staff Member, Board of Registration in Medicine

Tammi McManus

RECEIVED

NEW JERSEY DIVISION OF
CONSUMER AFFAIRS

Paul R. R
Actin

License Information

Accurate as of November 18, 2019 11:20 AM

Return to Search Results

Name: JAMIE PHIFER

Address: Seattle,WA

Profession/License Type: Medical Examiners,Medical Doctor

License No: 25MA10601400

License Status: Active

Status Change Reason: License Issuance

Issue Date: 5/21/2019

Expiration Date: 6/30/2021

Documents

NO Board Actions. For more information contact New Jersey State Board of Medical Examiners (609)826-7100

No Public Documents

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NOV 2019

NYSED.gov

OP Office of the Professions

Office of the Professions

Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

License Information *

11/18/2019

Name : PHIFER JAMIE MICHELE
Address : SEATTLE WA
Profession : MEDICINE
License No: 301876
Date of Licensure : 11/06/2019
Additional Qualification :
Status : REGISTERED
Registered through last day of : 10/21
Medical School: UNIVERSITY OF FLORIDA **Degree Date :** 05/14/2011

(Use your browser's back key to return to licensee list.)

* Use of this online verification service signifies that you have read and agree to the terms and conditions of use. See HELP glossary for further explanations of terms used on this page.

Note: The Board of Regents does not discipline *physicians(medicine), physician assistants,* or *specialist assistants.* The status of individuals in these professions may be impacted by information provided by the NYS Department of Health. To search for the latest discipline actions against individuals in these professions, please check the New York State Department of Health's Office of Professional Medical Conduct homepage.

Further information on physicians may be found on the following external sites (The State Education Department is not responsible for the accuracy or completeness of information located on external Internet addresses.):

American Board of Medical Specialties

American Medical Association:
- For the general public: AMA Physician Select, On-line Doctor Finder
- For organizations that verify physician credentials: AMA Physician Profiles

American Osteopathic Association, AOA-Net

Association of State Medical Board Executive Directors-(A.I.M."DOCFINDER")

New York State Department of Health Physician Profiles

The following sites provide additional information concerning the medical profession:

CLEAR (Council on Licensure, Enforcement and Regulation)

Federation of State Medical Boards

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WASHINGTON
Medical
Commission
Licensing. Accountability. Leadership.

October 11, 2019

ARKANSAS STATE MEDICAL BOARD
2100 RIVERFRONT DR
LITTLE ROCK, AR 72202

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon License for JAMIE MICHELE PHIFER.

You may see blank sections because we do not have the information in our database or it is not applicable for this credential type. This information is valid from the date of this letter.

Credential Number:	MD.MD.60359609
Credential Type:	Physician And Surgeon License
Current Credential Status:	ACTIVE
First Credential Date:	07/05/2013
Current Expiration Date:	08/25/2020
Last Renewal Date:	07/30/2018
DISCIPLINARY ACTION:	No

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NOV 2019

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Medical
Commission
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October 11, 2019

ARKANSAS STATE MEDICAL BOARD
2100 RIVERFRONT DR
LITTLE ROCK, AR 72202

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon Residency License for JAMIE MICHELE PHIFER.

You may see blank sections because we do not have the information in our database or it is not applicable for this credential type. This information is valid from the date of this letter.

Credential Number:	MDRE.ML.60224778
Credential Type:	Physician And Surgeon Residency License
Current Credential Status:	CLOSED
First Credential Date:	06/14/2011
Current Expiration Date:	07/05/2013
Last Renewal Date:	06/11/2012
DISCIPLINARY ACTION:	No

This license information was last updated on: 10/11/2019

If you have questions, please call (360)-236-2750 or visit our Online Provider Credential Search at https://wmc.wa.gov

THE SEAL OF THE STATE OF WASHINGTON 1889

Kimberly M. Romero, Licensing Manager

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NOV 18 2019

M152

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: October 25, 2019

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: Swedish Medical Group
ATTN:
Address Line 1: 600 University St #1200
Address Line 2:
City, State, ZIP Code: Seattle, WA 98101

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Phifer, Jamie Michele	XXX-XX- ___	

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature: Jamie Phifer — Date Signed (mm/dd/yyyy): 10 / 25 / 2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above): Swedish Medical Group

Employment Status: ☒ Current ☐ Inactive ☐ Leave of Absence ☐ Other ____

Date Employment Began	Date Employment Ended	
06/21/2011	06 24 2014	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: See next page

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).

☐ Yes ☐ No ☒ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date
Cheryl White		101301 2019
Type or legibly print name	**Position/Title**	
Cheryl White	Sr HRSC Adviser	
Phone Number	**Fax Number**	**E-mail Address**
888-681-3753	___	HRServiceCenter@providence.org

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ENTERED NOV 2019

ARKANSAS STATE MEDICAL BOARD
LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: 06/13/2019

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT--REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: All Women's Care
ATTN:
Address Line 1: 9730 3rd Ave
Address Line 2: #200
City, State, ZIP Code: Seattle, WA 98115

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Phifer, Jamie Michele	XXX-XX-___ ___ ___ ___	

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Jamie Phifer	06 / 13 / 2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above): All Women's Care

Employment Status
☐ Current ☒ Inactive ☐ Leave of Absence ☐ Other

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
1 / 1 / 2015	3 / 1 / 2019	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Physician

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed)
☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date
[signature]	6/13/2019

Type or legibly print name	Position/Title
Kaitlin McNatt	Office Manager

Phone Number	Fax Number	E-mail Address
206.985.9553	206.985.9806	Katy@awcseattle.com

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

MISC

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: October 25, 2019

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: Swedish Medical Group
ATTN:
Address Line 1: 600 University St #1200
Address Line 2:
City, State, ZIP Code: Seattle, WA 98101

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Phifer, Jamie Michele	XXX-XX-	

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Jamie Phifer	10 / 25 / 2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above): Swedish Medical Group

Employment Status: ☒ Current ☐ Inactive ☐ Leave of Absence ☐ Other

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
08/26/2014	Present	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Physician Family Practice

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).

☐ Yes ☐ No ☒ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date
Cheryl White	10/30/2019

Type or legibly print name	Position/Title
Cheryl White	Sr HR&C Advisor

Phone Number	Fax Number	E-mail Address
888-687-3753		HRServiceCenter@providence.org

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

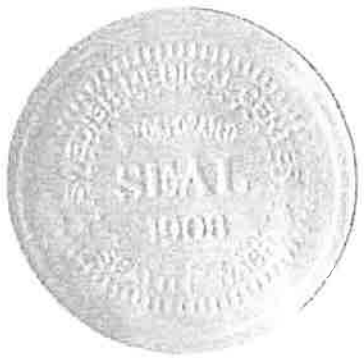
ENTERED NOV 1 2019

Provider Name: Jamie M. Phifer, MD Family Medicine						
Campus Address	Interim Appointment	Initial Appointment	Last Appointment	Next Appointment	Resigned	Status Privileges Class
Swedish Ballard Campus 5300 Tallman Ave. NW Seattle, WA 98107-3932	N/A	8/27/2014	6/27/2018	6/27/2020	N/A	Active w/Refer and Follow
Previous appointment	N/A	N/A	N/A	N/A	N/A	N/A
Swedish Cherry Hill Campus (formerly Providence Seattle) 500 17th Ave. Seattle, WA 98122	N/A	8/27/2014	6/27/2018	6/27/2020	N/A	Active w/Refer and Follow
Previous appointment	N/A	N/A	N/A	N/A	N/A	N/A
Swedish Edmonds Campus (formerly Stevens Hospital) 21601 76th Ave. W. Edmonds, WA 98026	N/A	N/A	N/A	N/A	N/A	N/A
Previous appointment	N/A	N/A	N/A	N/A	N/A	N/A
Swedish First Hill Campus (includes Mill Creek and Redmond) 747 Broadway Seattle, WA 98122	N/A	8/27/2014	6/27/2018	6/27/2020	N/A	Active w/Refer and Follow
Previous appointment	N/A	N/A	N/A	N/A	N/A	N/A
Swedish Issaquah Campus 751 NE Blakely Drive Issaquah, WA 98029	N/A	N/A	N/A	N/A	N/A	N/A
Previous appointment	N/A	N/A	N/A	N/A	N/A	N/A

SMC Main = First Hill, Ballard and Cherry Hill and includes the following:

Swedish Heart & Vascular Institute
Swedish Neuroscience Institute
Swedish Cancer Institute
Swedish Orthopedic Institute
Swedish Redmond Campus
Swedish Mill Creek Campus
Swedish Express Care and Urgent Care Clinics

NOTE: Employment for all Providence related facilites is verified through:
www.QuickConnfm.com



Swedish - Main Campus (FH, BAL, & CH)

Delineation Of Privileges

Provider Name: Phifer, Jamie M., MD - Active
Appointment: 06/27/2018 - 06/27/2020

Privilege Status	
Refer & Follow	
Approved	Read/Review Hospital Medical Records
Approved	Write Observations in Medical Record/chart to Help Guide Patient Care (May Not Write Orders)
Approved	Consult on patient if requested (end of life care, etc.)

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: 11/11/19

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: 98point6
ATTN:
Address Line 1: 701 5th Ave STE 2300
Address Line 2:
City, State, ZIP Code: Seattle, WA 98104

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Phifer, Jamie Michele	XXX-XX-	

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Jamie Phifer	11 / 11 / 2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above): 98point6

Employment Status: ☑ Current ☐ Inactive ☐ Leave of Absence ☐ Other

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
9 / 13 / 2019	Present	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Telemedicine Physician

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).

☑ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)	Signature Date
Sydney Carson	11 / 11 / 19

Type or legibly print name	Position/Title
Sydney Carson	Clinical Operations Coordinator – Lead

Phone Number	Fax Number	E-mail Address
866-657-7991	206-701-9452	Sydney@98point6.com

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

AMA Physician Profile

Name and Mailing Address

JAMIE MICHELE PHIFER
STE 100
550 16TH AVE
SEATTLE, WA 98122-5636

Primary Office Address

STE 200
9730 3RD AVE NE
SEATTLE, WA 98115-2023

Phone UNKNOWN

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty FAMILY MEDICINE (primary)
UNSPECIFIED (secondary)

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

AMA membership status NON MEMBER

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

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
	06/07/2011	NOT RPTD	NOT RPTD	NOT RPTD	09/16/2019

Current and/or historical medical school

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

Degree Awarded: YES

Degree Year: 2011

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

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

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

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

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

Sponsoring Institution:	SWEDISH MEDICAL CENTER
Sponsoring State:	WASHINGTON
Program name:	SWEDISH MEDICAL CENTER/CHERRY HILL PROGRAM
Specialty:	FAMILY MEDICINE
Training Type:	
Dates:	6/2011 - 6/2014 (Verified)

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 0

Specialty Board Certification

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

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

Certifying board: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY MEDICINE
Certificate type: GENERAL

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
MOC+	Active	06/25/2014	n/a	02/15/2020	INITIAL	09/23/2019	Y

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

+The above certifying board has implemented standards which specify that the board certification is contingent upon meeting ongoing requirements of Maintenance of Certification (MOC). Only certificates issued by a MOC participating board will reflect a reverification date.

Current and/or historical medical licensure

License No.	MD / DO	Jurisdiction	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported
D87604	MD	MD	05/30/2019	09/30/2021	01/01/2019	ACTIVE	UNLTD	10/01/2019
25MA10601400	MD	NJ	05/21/2019	06/30/2021		ACTIVE	UNLTD	09/13/2019
MD60359609	MD	WA	07/05/2013	08/25/2020	07/30/2018	ACTIVE	UNLTD	10/02/2019
ME0125540	MD	FL	09/08/2015	01/31/2020		ACTIVE	UNLTD	10/02/2019
04-40305	MD	KS	08/11/2017	07/31/2018		INACTIVE	UNLTD	07/02/2018
ML60224778	MD	WA	06/14/2011	07/05/2013	06/11/2012	INACTIVE	LTD	10/02/2019

Action Notifications

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

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

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

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration Date	Last Reported Date	Address
	22N 33N 4 5	03/31/2021	09/23/2019	600 University St Ste 1200 Seattle, WA 98101-3300

Only the last three characters of active DEA numbers are displayed

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

ECFMG Certification

Applicant Number:

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

Profile Information

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

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

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

ARKANSAS STATE MEDICAL BOARD

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ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE ANNOTATED SECTION 17-95-101, et. seq., AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD.

Jamie M Phifer, MD
Physician's Full Name (First Middle Last, Suffix, Degree)

Physician's Signature (no rubber stamps)

11/7/19
Signature Date

THIS IS A REQUIREMENT FOR LICENSURE.
YOUR LICENSURE APPLICATION WILL NOT BE PROCESSED
WITHOUT THIS COMPLETED FORM.

2019 NOV 13 AM 11:32

ENTERED
NOV 18 2019

ARKANSAS STATE MEDICAL BOARD

& CENTRALIZED CREDENTIALS VERIFICATION SERVICE
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any physicians with whom I have been associated; employees and medical staff members of any medical facility or hospital where I have been employed, on staff, or associated; any employees of any malpractice insurance carriers; any state medical licensing boards where I have been licensed or have applied for a license; any medical clinics where I have been employed or associated; and any medical schools where I have attended, to give to, copy for, or permit the personal inspection by employees or representatives of the Arkansas State Medical Board of any and all personnel records, disciplinary records, work records, military records, professional performance reviews, and/or evaluations of my performances.

I hereby release and discharge you and any other individuals or organizations referred to in this Authorization, and release you of any confidentiality requirements that might bind you, so that you may carry out the purposes of this document.

A copy of this document* may be provided to entities listed above, and this Authorization shall remain in effect for a period not to exceed two (2) years or until specifically revoked by me in writing.

Typed or Printed Name of Physician: Jamie M Phifer, MD

Social Security Number: _____

Signature of Physician: _____
Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: 11/7/19

**** This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas State Law.***

ENTERED
NOV 8 2019

Jamie M Phifer, MD

EXPERIENCE

98point6, Telemedicine Physician. Seattle, WA. September
September 2019 - present

Swedish Medical Group, Primary & Urgent Care Physician. Seattle, WA. August
August 2014-present

EDUCATION

Swedish Cherry Hill Family Medicine Residency; Seattle, WA
June 2011 - June 2014
Carolyn Downs FQHC Site - Culturally competent primary care to majority underserved African American, Latino and diverse immigrant population

University of Florida College of Medicine; Gainesville, FL
August 2007 - May 2011
Doctor of Medicine, Cum laude

University Florida College of Liberal Arts and Sciences; Gainesville, FL
August 2003 - May 2007
Bachelor of Science in Interdisciplinary Studies: Microbiology with a focus in Entrepreneurship, Summa cum laude

11/7/19