

Jamie Michele Phifer, MD

Licensed Physician #MD2020-0021

Issue Date	Expiration Date
01/09/2020	07/01/2021
Signature of Holder	

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

**New Mexico Medical Board  
Triennial Renewal Certificate**

This is to certify that

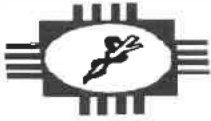
**Jamie Michele Phifer, MD**  
License Number: MD2020-0021

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 01/09/2020    Date Expires: 07/01/2021\*

*\*A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

**This License Must Be Conspicuously Posted In Each Practice Location**



**The New Mexico Statewide Application  
for Physician/Practitioner Appointment©  
Physician (MD) Application**

Date of Application: November 1, 2019

Application Fee: **400.00**

*R#: 2239864*

*endorse*

**Demographics**

<b>Legal Name</b>	Phifer	Jamie	Michele
	Last	First	Middle
<b>Other Names Used</b>			

Will you be applying by endorsement Yes  No   
(See page 2 of the application instructions for requirements)

<b>Gender</b>	M <input type="checkbox"/> F <input checked="" type="checkbox"/>	<b>Place of Birth</b>	GA	<b>Citizenship</b>	USA
<b>Immigration Status</b>		<b>INS Certification #</b>			
<b>*Social Security Number</b>	██████████9454	<b>Date of Birth</b>	██████████	1985	
<b>*NM Tax ID# (if applicable)</b>		Pending	<input type="checkbox"/>		
<b>*Fed. Tax ID# (if applicable)</b>		Pending	<input type="checkbox"/>		
<b>Current Practice Name</b>	98point6				
<b>Practice Limited to: (Clinical Specialty)</b>	Family Medicine				
<b>Street</b>	701 5th Ave Ste 2300				
<b>City</b>	Seattle	<b>State</b>	WA	<b>Zip Code</b>	98104
<b>Telephone Number</b>	866-657-7991	<b>Facsimile</b>			
<b>*Office Manager or Contact Person:</b> Sydney Carson - sydney@98point6.com					
<b>Foreign Languages (spoken fluently by practitioner)</b>					
<b>Foreign Languages (spoken fluently at Practice)</b>					
<b>* E-Mail Address (confidential)</b> ██████████@98point6.com					
<b>*Current Mailing Address (if different from above -confidential unless no practice address indicated)</b>					
<b>*Street</b>	701 5th Ave Ste 2300				
<b>*City</b>	Seattle	<b>*State</b>	WA	<b>*Zip Code</b>	98104
<b>Telephone Number</b>		<b>Facsimile</b>			
<b>What are your immediate or future Practice Plans in New Mexico?</b>	98point6 physicians provide primary care services to patients remotely. 98point6 is located in Washington state and physicians may be located in any state across the country. I will mainly be practicing from my home address.				
<b>Home Address (Required)</b>	<b>*Telephone Number</b> ██████████7991				
<b>Street</b>	██████████				
<b>*City</b>	Seattle	<b>*State</b>	WA	<b>*Zip</b>	98115

<b>Practice Associates in NM (If Applicable)</b>		<b>Call Coverage in NM (If Applicable)</b>	
N/A			
<b>Other Practice Locations (If Applicable)</b>			
<b>Practice Name</b>		N/A	
Street			
City		State	Zip Code
Telephone Number		Facsimile	
Answering Service		Effective Date	

**Education** (Please attach a separate sheet, if necessary.)

<b>Undergraduate Education</b>			
<b>College or University</b>		University of Florida	
City	Gainesville	State/Country	FL
Zip Code:	32611		
Dates Attended	From: 08/25/2003	To: 05/14/2007	Degree BA
Graduation Date	05/14/2007		
<b>College or University</b>			
City		State/Country	
Zip Code:			
Dates Attended	From:	To:	Degree
Graduation Date			
<b>Professional / Medical Education</b>			
<b>College or University</b>		University of Florida College of Medicine	
City	Gainesville	State/Country	FL USA
Zip Code:	32610		
Dates Attended	From: 08/13/2007	To: 05/15/2011	Degree MD
Graduation Date	05/15/2011		
<b>College or University</b>			
City		State/Country	
Zip Code:			
Dates Attended	From:	To:	Degree
Graduation Date			
<b>Graduate Education</b>			
<b>College or University</b>			
City		State/Country	
Zip Code:			
Dates Attended	From:	To:	Degree
Graduation Date			
<b>College or University</b>			
City		State/Country	
Zip Code:			
Dates Attended	From:	To:	Degree
Graduation Date			
<b>Internship/ Residency/ Fellowship</b>			
<b>Institution Name</b>		Swedish Cherry Hill Family Medicine Residency	
City	Seattle	State/Country	WA
Zip Code:	98122		
Dates Attended	From: 06/21/2011	To: 06/24/2014	Field Family Medicine
<b>Institution Name</b>			
City		State/Country	
Zip Code:			
Dates Attended	From:	To:	Field
<b>Institution Name</b>			
City		State/Country	
Zip Code:			
Dates Attended	From:	To:	Field
<b>Institution Name</b>			
City		State/Country	
Zip Code:			
Dates Attended	From:	To:	Field

**Work History** Please list all previous practice experience for the last 15 years, including military or government service, listing the most recent first. If military service, state type of discharge and rank achieved and **attach copy of discharge or separation documents**. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

<b>Location</b>	98point6	From	09/13/2019	To	Present
Street	701 5th Ave Ste 2300	Phone Number			
City	Seattle	State	WA	Zip Code	98104
Type of Practice	Telemedicine	Contact Person	Sydney Carlson		
Type of Discharge		Rank Achieved			
<b>Location</b>	Swedish Medical Group	From	08/26/2014	To	Present
Street	600 University St #1200	Phone Number			
City	Seattle	State	WA	Zip Code	98101
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

**Hospital and Health Facility Affiliation History** (other than postgraduate training)  N/A

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. **Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.**

<b>(1) Current Primary Admitting Facility</b> (Hospital Name)		N/A			
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	<b>From:</b>	<b>To:</b>			
Type of Appointment					
Privileges Assigned					
<b>(2) Facility Name</b>					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	<b>From:</b>	<b>To:</b>			
Type of Appointment					
Privileges Assigned					
<b>(3) Facility Name</b>					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	<b>From:</b>	<b>To:</b>			
Type of Appointment					
Privileges Assigned					



<b>(4) Facility Name</b>				
Street				
City		State	Zip Code	
Telephone Number			Facsimile	
Appointment Dates		From:	To:	
Type of Appointment				
Privileges Assigned				
<b>(5) Facility Name</b>				
Street				
City		State	Zip Code	
Telephone Number			Facsimile	
Appointment Dates		From:	To:	
Type of Appointment				
Privileges Assigned				
<b>(6) Facility Name</b>				
Street				
City		State	Zip Code	
Telephone Number			Facsimile	
Appointment Dates		From:	To:	
Type of Appointment				
Privileges Assigned				
<b>(7) Facility Name</b>				
Street				
City		State	ZIP Code	
Telephone Number			Facsimile	
Appointment Dates		From:	To:	
Type of Appointment				
Privileges Assigned				
<b>(8) Facility Name</b>				
Street				
City		State	Zip Code	
Telephone Number			Facsimile	
Appointment Dates		From:	To:	
Type of Appointment				
Privileges Assigned				

**Professional References** Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

<b>(1) Name and Title</b>				
Amanda Cuda		MD		
Address 701 5th Ave STE 2300 (amanda@98point6.com)				
City Seattle		State WA	Zip Code 98104	
Telephone Number 866-657-7991			Facsimile	
<b>(2) Name and Title</b>				
Michael Grabinski		MD		
Address 701 5th Ave STE 2300 (Michael@98point6.com)				
City Seattle		State WA	Zip Code 98104	
Telephone Number 866-657-7991			Facsimile	
<b>(3) Name and Title</b>				
Brad Younggren		MD		
Address 701 5th Ave STE 2300 (Brad@98point6.com)				
City Seattle		State WA	Zip Code 98104	
Telephone Number 866-657-7991			Facsimile	

### Licensure-Registration-Certification Information

<b>ECFMG Number (if applicable)</b>								
<b>State Professional License/Certification Number</b>				MD60359609				
State	WA	Issue Date	07/05/2013	Expiration Date	08/25/2020	Pending	<input type="checkbox"/>	
<b>All Other State License Numbers (regardless of status - attach separate list if necessary.)</b>								
<b>State</b>	<b>Number</b>		<b>Issue Year</b>		<b>Expiration Date</b>			
FL	ME125540		2015		01/31/2020			
IL	036150427		2019		07/31/2020			
MA	281320		2019		08/25/2020			
<b>*Federal Drug Enforcement Admin. (DEA) Registration</b>						N/A	<input type="checkbox"/>	
Number		8842		Exp. Date	03/31/2021		Pending	<input type="checkbox"/>
<b>*State Controlled Substance Registration (CSR)</b>						N/A	<input checked="" type="checkbox"/>	
Number		State		Exp. Date		Pending		<input type="checkbox"/>
<b>*Medicare Unique Physician Identification Number (UPIN)</b>						N/A		
Pending <input type="checkbox"/>								
<b>*State Medicaid Provider Number</b>						N/A		
Pending <input type="checkbox"/>								
<b>*National Provider Identification Number</b>						1154615185		
Pending <input type="checkbox"/>								

### Specialty Board Certifications N/A

**Are you Board Certified?**  Yes  No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

<b>Certified/Recertified by the:</b>			
1. Family Medicine			
Date Certified	06/25/2014	Date Last Recertified	Expiration Date 06/25/2024
2.			
Date Certified		Date Last Recertified	Expiration Date
3.			
Date Certified		Date Last Recertified	Expiration Date
<b>Accepted for Examination by the:</b>			
Until (expiration date)		If not accepted, have you made application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Certified/Recertified by the Subspecialty Board of</b>			
1.			
Date Certified		Date Last Recertified	Expiration Date
2.			
Date Certified		Date Last Recertified	Expiration Date
<b>Accepted for Examination by the Subspecialty Board of</b>			

### Professional Liability Insurance (confidential information)

Do you have current liability insurance? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Current Carrier</b>		Columbia Casualty Company	Current <input checked="" type="checkbox"/> Pending <input type="checkbox"/>
Address 151 N Franklin St, Chicago, IL 60606			
Dates Insured	From	To	Policy # Coverage Limits
	1/17/19	1/17/20	

**Licensing Exam:** Please check all that apply:

**State Board Exam (Prior to 1973)** Which state? \_\_\_\_\_ Date(s) passed? \_\_\_\_\_

**FLEX**       **LMCC**       **National Board (NBME)**       **USMLE**

Part/Step 1 Date Passed 06/30/2009      Part/Step 2 Date Passed 09/03/2010      Part/Step 3 Date Passed 05/07/2013  
 Month/Year      Month/Year      Month/Year

**Professional Practice Questions** Please answer ALL of the following Yes or No questions. If you answer YES to 1-19 and 21, and/or NO to 20, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
2. Have you ever been denied professional liability insurance coverage?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
7. Have you ever been named as a defendant in any criminal proceedings?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency unrelated to your professional competence or conduct?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
c. Have you ever been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
b. Are any currently held licenses pending investigation or being challenged?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

<p><b>15.</b> Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? <b>If yes, please provide the following information on the attached Malpractice History form for each case:</b></p> <ul style="list-style-type: none"> <li>• Name, age, sex of patient/claimant.</li> <li>• Date(s) and type of treatment and/or surgery, which led to the allegations against you.</li> <li>• Nature of allegations in claims/suits. Specify whether a suit was ever filed.</li> <li>• Names of other practitioners and hospital, if any, involved in claims or suit.</li> <li>• Disposition or current status of claim or suit (be specific).</li> <li>• Name of insurance carrier defending you.</li> <li>• Name of defense attorney.</li> </ul>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
<p><b>16.</b> Have you ever been reported to the National Practitioner Data Bank?</p>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
<p><b>17. a)</b> Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?</p> <p><b>b)</b> Are you being treated with opiates for chronic pain? If yes, please provide to the Board upon application a current evaluation from your treating pain provider (MD or DO).</p>		
<p><b>18.</b> In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? <b>If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.</b></p>		
<p><b>19.</b> Have you ever, for any reason:</p> <p><b>a)</b> Resigned from a medical school or postgraduate training (PGT) program?</p> <p><b>b)</b> Withdrawn from a medical school or postgraduate training program?</p> <p><b>c)</b> Been suspended, dismissed, or expelled from a medical school or PGT program?</p> <p><b>d)</b> Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?</p> <p><b>e)</b> Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?</p>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
<p><b>20.</b> I attest that I will limit my practice to areas in which I am competent to practice.</p>	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
<p><b>21.</b> Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?</p>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

**If you answer YES to questions 1-19 and 21, and/or NO to 20, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.**



**LICENSURE DATA**

**PRACTITIONER:** Jamie M Phifer, MD

<b>State</b>	<b>License #</b>	<b>Issued</b>	<b>Expiration</b>	<b>Status</b>
WA MD	MD60359609	07/05/2013	08/25/2020	Active
FL MD	ME125540	09/08/2015	01/31/2020	Active
IL MD	036150427	08/07/2019	07/31/2020	Active
MA MD	281320	09/26/2019	08/25/2020	Active
MD MD	D87604	05/30/2019	09/30/2021	Active
NJ MD	25MA10601400	05/21/2019	06/30/2021	Active
KS MD	04-40305	08/11/2017	07/31/2018	Expired

New Mexico Medical Board  
2055 S. Pacheco St. Bldg. 400  
Santa Fe, NM 87505 (505) 476-7220

**APPLICANT'S OATH**

I, Jamie M Phifer, MD, hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.



Jamie Phifer 11-1-19  
Applicant Signature Date

\*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name Jamie M Phifer, MD

Date 11/1/19

For State Board Use Only

**Affidavit and Authorization for Release of Information**

**Applicant:** In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

**Send this form to the board you are applying to for licensure.** Include all other required materials. A directory of state medical and osteopathic boards is available at <http://www.fsmb.org/policy/contacts>.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

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

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



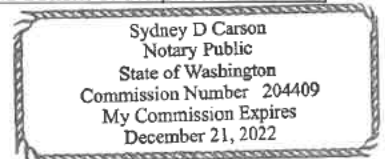
*Jamie Phifer*  
 Applicant's signature (must be signed in the presence of a notary)

Phifer, Jamie Michele  
 Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

11-1-19  
 Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

**NOTARY**



State of Washington, County of King

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 1 day of Nov, 2019.

Notary Public Signature *Sydney D Carson* My Notary Commission Expires 12-21-22

# Jamie M Phifer, MD

7791 ◊ @98point6.com

## 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





# AMA Physician Profile

PREPARED FOR

New Mexico Medical Board, Santa Fe, NM

**Name and Mailing Address**

JAMIE MICHELE PHIFER



SEATTLE, WA 98122-5636

**Primary Office Address**

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

**Birth date** [REDACTED] 1985

**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** MEMBER

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

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**Current and/or historical NPI information**

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1154615185	06/07/2011	NOT RPTD	NOT RPTD	NOT RPTD	10/18/2019

**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 <sup>+</sup>	Active	06/25/2014	n/a	02/15/2020	INITIAL	10/17/2019	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.

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+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	11/01/2019
25MA10601400	MD	NJ	05/21/2019	06/30/2021		ACTIVE	UNLTD	10/18/2019
281320	MD	MA	09/26/2019	08/25/2020		ACTIVE	UNLTD	10/25/2019
MD60359609	MD	WA	07/05/2013	08/25/2020	07/30/2018	ACTIVE	UNLTD	11/01/2019
ME0125540	MD	FL	09/08/2015	01/31/2020		ACTIVE	UNLTD	11/04/2019
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	11/01/2019

#### 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
XXXXXX842	22N 33N 4 5	03/31/2021	11/04/2019	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.



**PRACTITIONER PROFILE**

Prepared for: **New Mexico Medical Board** As of Date:11/14/2019

**PRACTITIONER INFORMATION**

Name: Phifer, Jamie Michele  
 DOB: [REDACTED] 1985  
 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
1154615185	Individual			10/25/2019

**LICENSE HISTORY**

Jurisdiction	License Number	Issue Date	Expiration Date	Last Reported
FLORIDA	ME125540	09/08/2015	01/31/2020	11/14/2019
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	11/08/2019
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			11/08/2019
WASHINGTON	ML60224778	06/14/2011	07/05/2013	10/31/2019
WASHINGTON	MD60359609	07/05/2013	08/25/2020	10/31/2019

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**PRACTITIONER PROFILE**

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Prepared for: New Mexico Medical Board As of Date:11/14/2019  
Practitioner Name: Phifer, Jamie Michele

---

**US DRUG ENFORCEMENT ADMINISTRATION (DEA)**

<b>DEA Number</b>	<b>Schedule</b>	<b>Address</b>	<b>Expiration Date</b>	<b>Last Reported</b>
FP8597948	22N 33N 4 5	JACKSONVILLE, FL 32216	03/31/2022	10/15/2019
FP3498842	22N 33N 4 5	SEATTLE, WA 98121	03/31/2021	10/15/2019

**PRACTITIONER PROFILE**

Prepared for: New Mexico Medical Board As of Date: 11/14/2019  
 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.*

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**AOA® CERTIFICATION HISTORY**

No AOA Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county, & community



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
State Surgeon General

**Vision:** To be the **Healthiest State** in the Nation

---

October 11, 2019

New Mexico Medical Board  
2055 S. Pacheco, Bldg. 400  
Santa Fe, NM 87505

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.



---

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

 Accredited Health Department  
Public Health Accreditation Board





# 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

10/11/2019

Division of Professional Regulation

Date

Refer to the Department's Web Site at [www.idfpr.com](http://www.idfpr.com) to verify professional licenses via License Look-Up.



Kathleen Selzler Lippert  
Executive Director

Sam Brownback, Governor

October 11, 2019

New Mexico Medical Board  
2055 S. Pacheco, Bldg. 400  
Santa Fe, NM 87505

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
Date of Birth:	08/25/1985
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)



# Maryland Board of Physicians

 Print Profile

## Physician Profile Portal

**License Number: D87604 Dr. Jamie Michele Phifer**

License Type: Physician-Medical Doctor

Special License Category: N/A

License Status: **Active**

Licensed Issued: 05/30/2019 License Expiration: 09/30/2021

### Primary Practice Setting

98point6  
701 5th Ave  
STE 2300  
Seattle, WA 98104

### Public Address

701 5th Ave  
Ste 2300  
  
Seattle, WA 98104

### 📌 Education

---

UNIV OF FL COLL OF MED  
Graduated: 2011

### 📌 Medical Assistance and Malpractice Insurance

---

Accept Medicaid? No

Maintains Malpractice Insurance? Yes

### 📌 Postgraduate Training Program

*No reported Other Regulatory Board, Agency Public Actions, or Administrative Fines for this licensee.*

### 🔍 MALPRACTICE

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Malpractice (Information to be taken into consideration when reviewing a Licensee's profile)

📄 Please Read Malpractice Disclosure

▶ **Malpractice Judgments and Arbitration Awards** (within the past 10 years)

*None Reported*

▶ **Malpractice Settlements**

(If there are 3 or more settlements of \$150,000 or greater within the past 5 years)

*None Reported*

### 🔍 Convictions for any crime involving moral turpitude

---

*None reported by the courts.*

Maryland Board of Physicians 4201 Patterson Avenue Baltimore, MD 21215  
410.764.4777 | Toll Free 800.492.6836





# Commonwealth of Massachusetts Board of Registration in Medicine

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

[www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)

Enforcement Division  
Legal Division  
Licensing Division

Fax: (781) 876-8381  
Fax: (781) 876-8380  
Fax: (781) 876-8383

CANDACE LAPIDUS SLOANE, MD  
Chair, Physician Member

GEORGE ABRAHAM, MD  
Vice Chair, Physician Member

JULIAN N. ROBINSON, MD  
Secretary, Physician Member

WOODY GIESSMANN, LADC-I, CADAC, CIP, CAI  
Public Member

MICHAEL D. MEDLOCK, MD  
Physician Member

PAUL G. GITLIN, ESQ.  
Public Member

GEORGE ZACHOS, ESQ.  
Executive Director

CHARLES D. BAKER  
Governor

KARYN E. POLITO  
Lieutenant Governor

MARYLOU SUDDERS  
Secretary  
Health and Human Services

MONICA BHAREL, MD, MPH  
Commissioner  
Department of Public Health



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](http://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.

SEAL

Staff Member, Board of Registration in Medicine

Tammi McManus



PHILIP D. MURPHY  
Governor

SHEILA Y. OLIVER  
Lt. Governor

# New Jersey Office of the Attorney

Division of Consumer Affairs  
State Board of Medical Examiners  
P.O. Box 183, Trenton, NJ 08625-0183



GURBIR S. GREWAL  
Attorney General

PAUL R. RODRIGUEZ  
Acting Director

October 28, 2019

New Mexico Medical Board  
2055 South Pacheco Street, Building 400  
Santa Fe, NM 87505-0503

**For Delivery Services:**  
140 East Front St.  
PO Box 183 2<sup>nd</sup> Floor  
Trenton, NJ 08608  
(609) 826-7100  
(609) 777-0956 FAX

To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by JAMIE PHIFER to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that JAMIE PHIFER was issued a New Jersey license 25MA10601400 on or about 05/21/2019 and is currently Active with an expiration date of 06/30/2021. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,  
BOARD OF MEDICAL EXAMINERS

William V. Roeder  
Executive Director

WVR/sdp

## Search for a Physician

- About the Physician Profile
- Physicians: Update your profile
- FAQ
- Search Tips
- Dictionary
- Disclaimers
- Contact Us
- Give Us Your Feedback

Leave this site:

- [Link to NYS DOH Home Page, or](#)
- [Link to NYS DOH Center for Consumer Health Care Information](#)

## Physician

[Back to Search Results](#)

[Select items to print](#)

### Jamie Michele Phifer

NYS License Number: 301876  
 Date of NYS Licensure: 11-06-2019  
 National Provider ID:

Office Locations:  
**Profile under Development**  
 Profile last updated by physician:

• Education	• Practice Info	• Legal Actions	• Professional Activities	• Statement
• Malpractice	• NY Licensee Actions	• Out-of-State Actions	• Current Limitations	
• Hospital Restrictions	• Criminal Convictions			

#### Malpractice [TO TOP](#)

Profile under Development

**Note:** Malpractice information continues to be collected and reviewed. You should check periodically to see if information has been added or updated.

#### NY Licensee Actions [TO TOP](#)

The Department of Health Office of Professional Medical Conduct (OPMC) is responsible for investigating allegations of misconduct against physicians. The State Board for Professional Medical Conduct is authorized under Public Health Law to take action on a doctor's medical license if the doctor is found to be guilty of Professional Misconduct. If you would like to see if there have been any license actions taken against this doctor over the past 10 years, you may click here: [OPMC](#). This will take you to the OPMC Web site. If there have not been any license actions against this doctor in New York over the past ten years, the OPMC screen will tell you that. When you want to return to this Physician Profile you must click on the X in the upper right corner of the OPMC window.

#### Out-of-State Actions [TO TOP](#)

Profile under Development

#### Current Limitations [TO TOP](#)

Profile under Development

#### Hospital Privilege Restrictions [TO TOP](#)

Profile under Development

#### Hospital Failure to Renew Privileges [TO TOP](#)

Profile under Development

#### Criminal Convictions [TO TOP](#)

Profile under Development

## Department of Health

### Professional Misconduct and Physician Discipline



[New Physician Search](#)

**Search**

**0 documents found**



**Results -**

[Physician Records](#)

On: 12/17/2019 10:36 AM

**You searched for:** Last Name: PHIFER First Name: Middle Name:

License: 301876 Type:

Effective Date From: 12/17/2009 Effective Date To: \_\_\_\_\_

Update Date From: \_\_\_\_\_ Update Date To: \_\_\_\_\_

**\* If there is a list of name(s) above, click on each name to see the disciplinary information.**

**If there is no list of names, there is no public disciplinary action that matches what you entered for the search.**

**Reminder: This database contains public disciplinary actions for 1990 and later.**

[Return to Professional Misconduct and Professional Discipline](#)  
[Return to Welcome Page](#)

Send questions or comments to:  
[opmc@health.ny.gov](mailto:opmc@health.ny.gov)

[Home Page](#) / [From the Commissioner](#) / [Directory Services](#) / [Vital Records](#) /  
[Info for Consumers](#) / [Info for Providers](#) / [Info for Researchers](#) /  
[Public Health Forum](#) / [What's New](#) / [HELP!](#) / [Search our Web Site](#)

Questions or comments: [nhinfo@health.ny.gov](mailto:nhinfo@health.ny.gov) Revised: March 2017

**FACEBOOK**

**TWITTER**

**YOUTUBE**

**PINTEREST**



**Search for a Physician**

- About the Physician Profile
- Physicians: Update your profile
- FAQ
- Search Tips
- Dictionary
- Disclaimers
- Contact Us
- Give Us Your Feedback

- Leave this site:
- Link to NYS DOH Home Page, or
  - Link to NYS DOH Center for Consumer Health Care Information

**Physician**

[Back to Search Results](#)

[Select Items to print](#)

**Jamie Michele Phifer**

NYS License Number: 301876  
 Date of NYS Licensure: 11-06-2019  
 National Provider ID:

Office Locations:  
**Profile under Development**  
 Profile last updated by physician:

- Education
- Practice Info
- Legal Actions
- Professional Activities
- Statement
- Malpractice
- NY Licensee Actions
- Out-of-State Actions
- Current Limitations
- Hospital Restrictions
- Criminal Convictions

**Malpractice**  [TO TOP](#)

Profile under Development

**Note:** Malpractice information continues to be collected and reviewed. You should check periodically to see if information has been added or updated.

**NY Licensee Actions**  [TO TOP](#)

The Department of Health Office of Professional Medical Conduct (OPMC) is responsible for investigating allegations of misconduct against physicians. The State Board for Professional Medical Conduct is authorized under Public Health Law to take action on a doctor's medical license if the doctor is found to be guilty of Professional Misconduct. If you would like to see if there have been any license actions taken against this doctor over the past 10 years, you may click here: [OPMC](#). This will take you to the OPMC Web site. If there have not been any license actions against this doctor in New York over the past ten years, the OPMC screen will tell you that. When you want to return to this Physician Profile you must click on the X in the upper right corner of the OPMC window.

**Out-of-State Actions**  [TO TOP](#)

Profile under Development

**Current Limitations**  [TO TOP](#)

Profile under Development

**Hospital Privilege Restrictions**  [TO TOP](#)

Profile under Development

**Hospital Failure to Renew Privileges**  [TO TOP](#)

Profile under Development

**Criminal Convictions**  [TO TOP](#)

Profile under Development



October 11, 2019

NEW MEXICO MEDICAL BOARD  
2055 S. PACHECO, BLDG. 400  
SANTA FE, NM 87505

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.*

<b>Year of Birth:</b>	1985
<b>Credential Number:</b>	MD.MD.60359609
<b>Credential Type:</b>	Physician And Surgeon License
<b>Current Credential Status:</b>	ACTIVE
<b>First Credential Date:</b>	07/05/2013
<b>Current Expiration Date:</b>	08/25/2020
<b>Last Renewal Date:</b>	07/30/2018
<b>DISCIPLINARY ACTION:</b>	No



October 11, 2019

NEW MEXICO MEDICAL BOARD  
2055 S. PACHECO, BLDG. 400  
SANTA FE, NM 87505

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.*

<b>Year of Birth:</b>	1985
<b>Credential Number:</b>	MDRE.ML.60224778
<b>Credential Type:</b>	Physician And Surgeon Residency License
<b>Current Credential Status:</b>	CLOSED
<b>First Credential Date:</b>	06/14/2011
<b>Current Expiration Date:</b>	07/05/2013
<b>Last Renewal Date:</b>	06/11/2012
<b>DISCIPLINARY ACTION:</b>	No

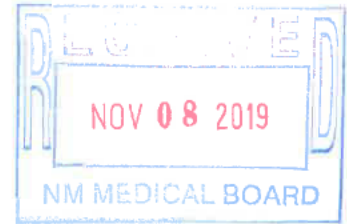
This license information was last updated on: 10/11/2019

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



Kimberly M. Romero, Licensing Manager

**New Mexico Medical Board**  
 2055 S. Pacheco St.  
 Building 400  
 Santa Fe, NM 87505  
 (505) 476-7220



**WORK EXPERIENCE VERIFICATION**

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Jamie Phifer  
 Applicant Name  
 Address  
 Seattle, WA 98104  
 City/State/Zip

*Jamie Phifer*  
 Applicant Signature  
 09/19 - present  
 Date of Privilege/Employment mm/yy to mm/yy (must be provided)  
 -7991  
 Telephone Number

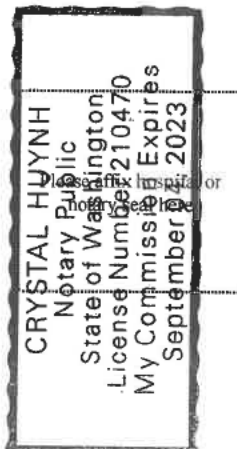
The section below should be completed by the chief of staff or facility's administrative staff. Letters of Recommendation are **NOT** accepted in lieu of this form.

*Sydney Carson*  
 Type or Print Name of person completing this form  
 Lead Clinical Operations Coordinator  
 Title  
 98point6  
 Name of Institution  
 701 5th Ave Ste 2300  
 Address  
 Seattle, WA 98104  
 City / State / Zip

- This evaluation is based on:  Observation of applicant  Review of personnel file
- In your estimation, is there any reason why this applicant should not be licensed to practice?  Yes  No
- To your knowledge, is there any mental or physical reason why this applicant should not be licensed?  Yes  No
- To your knowledge, is there any derogatory/disciplinary information regarding this applicant?  Yes  No
- Are the dates of privilege/employment provided by the applicant on this form accurate?  Yes  No

**\*If not, please provide correct dates:** Beginning \_\_\_\_\_ Ending \_\_\_\_\_  
 Month/Year Month/Year

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.



*Sydney Carson*  
 Printed name of person completing this form  
*Sydney Carson*  
 Signature  
 10/30/19  
 Date  
 Signature of Notary (if applicable)  
 10/30/19  
 Date  
 My commission expires: 09/04/2023

**Please note on this form if there is no hospital or notary seal available.**

Please return this form directly to the address above  
 Thank you for your cooperation.

New Mexico Medical Board  
2055 S. Pacheco St.  
Building 400  
Santa Fe, NM 87505  
(505) 476-7220



**WORK EXPERIENCE VERIFICATION**

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Jamie Phifer

Applicant Name

Address  
Seattle, WA 98101  
City/State/Zip

Applicant Signature

08/14 - present

\*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)

7991

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.  
Letters of Recommendation are **NOT** accepted in lieu of this form.

Mary F. White

Type or Print Name of person completing this form

Administrative Assistant II Medical Staff

Title

Swedish Medical Center

Name of Institution

747 Broadway

Address

Seattle, WA 98122

City / State / Zip

1. This evaluation is based on: \_\_\_ Observation of applicant X Review of <sup>Credentials</sup> personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? \_\_\_ Yes X No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? \_\_\_ Yes X No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? \_\_\_ Yes X No
5. Are the dates of privilege/employment provided by the applicant on this form accurate? \* X Yes \_\_\_ No

\*If not, please provide correct dates: Beginning \_\_\_\_\_ Ending \_\_\_\_\_  
Month/Year Month/Year

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.



Mary F. White

Printed name of person completing this form

Signature

10/28/2019

Date

Signature of Notary (if applicable)

Date

My commission expires: \_\_\_\_\_

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above  
Thank you for your cooperation.



Provider Name: Jamie M. Phifer, MD Specialty: 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 Previous appointment	N/A	8/27/2014	6/27/2018	6/27/2020	N/A	Active w/Refer & Follow			
Swedish Cherry Hill Campus (formerly Providence Seattle) 500 17th Ave. Seattle, WA 98122 Previous appointment	N/A	8/27/2014	6/27/2018	6/27/2020	N/A	Active w/Refer & Follow			
Swedish Edmonds Campus (formerly Stevens Hospital) 21601 76th Ave. W. Edmonds, WA 98026 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 Previous appointment	N/A	8/27/2014	6/27/2018	6/27/2020	N/A	Active w/Refer & Follow			
Swedish Issaquah Campus 751 NE Blakely Drive Issaquah, WA 98029 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 facilities is verified through:  
[www.QuickComfirm.com](http://www.QuickComfirm.com)

Phifer, Jamie Michele

Medical Doctor

MD2020-0021

	N	07/10/2020
1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	07/10/2020
2. Since your last renewal have you been denied professional liability insurance coverage?	N	07/10/2020
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	07/10/2020
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	07/10/2020
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	07/10/2020
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	07/10/2020
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	07/10/2020
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	07/10/2020
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	07/10/2020
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional	N	07/10/2020
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	07/10/2020
10. c. Since you last renewal, have you been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	N	07/10/2020
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	07/10/2020
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	07/10/2020
12. b. Are any currently held licenses pending investigation or being challenged?	N	07/10/2020
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	07/10/2020

	N	07/10/2020
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	N	07/10/2020
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	07/10/2020
16. Since your last renewal have you been reported to the National Practitioner Data Bank?		
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?		07/10/2020
18. Since your last renewal have you been diagnosed with an illness or condition which impairs your judgment or affects your ongoing ability to practice medicine in a competent, ethical and professional manner? <b>If yes, please have your treating physician send the NM		07/10/2020
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC	Y	07/10/2020
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	Y	07/10/2020
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	07/10/2020
21. Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?	N	07/10/2020