Board of Medicine

State of North Dakota

Certifies that

Jamie Michele Phifer, MD

having fulfilled all the requirements of the laws of the State of North Dakota and possessing the prescribed qualifications is hereby granted a license to practice medicine in the State of North Dakota.

Given under the hands and seal of the North Dakota Board of Medicine, on this 6th day of February in the year of Our Lord 2020, A.D.

No. 16347

North Dakota Board of Medicine

Established 1890

4204 Boulder Ridge Rd Suite 260 • Bismarck, ND 58503-6162
Phone (701) 450-4060 • Fax (701) 989-6392
www.ndbom.org

Bonnie Storbakken
Executive Secretary

Lynette McDonald
Deputy Executive Secretary

You have been issued your ND medical license through the IMLCC. However, the ND Board of Medicine requires you to answer the following questions and return to us via email, fax or mail no later than 30 days from the issuance date of your license.

Personal Data: (If any of the questions are answered "yes", full details must be furnished on a separate sheet and made a part of your application).

1. Have you ever had an application for a professional license denied?.....
2. Have you ever been investigated and/or disciplined by any licensing board, agency, professional association or medical facility?.....
3. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence or been placed on probation or reprimanded at a medical school or postgraduate training program?.....
4. Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict, deny or limit a professional license?.....
5. Have you ever been subject to informal or formal proceedings which might have resulted in the surrender of a state and/or federal narcotic registration certificate?.....
6. Have you ever had hospital and/or clinic privileges denied, removed or restricted, or limitations imposed on such privileges or resigned hospital and/or clinic privileges to avoid formal action? .....
7. Are you now or have you ever been named as a defendant or respondent in any malpractice proceeding?.....
8. Have you ever been arrested for, or charged with, any crime?.....
9. Within the last two years have you been treated for any physical, mental or emotional condition which impaired or could be said to impair your ability to practice medicine safely and competently? You may answer no to this question if you have a current contract with the North Dakota Professional Health Program (NDPHP) or a professional health program in another state? .....
10. Do you currently have or within the past two years have you had a dependency on the use of or engaged in the excessive or habitual use of alcohol or drugs which impaired or does impair your ability to practice medicine safely and competently? You may answer no to this question if you have a current contract with the North Dakota Professional Health Program (NDPHP) or a professional health program in another state.

[redacted]

PRECRIPTION DRUG MONITORING PROGRAM (PDMP) CERTIFICATION

☑ I certify that I understand and will comply with Chapter 50-05-02 (PDMP Rule), even if it doesn't currently pertain to my practice. **(certify by checking the box)**

Jamie Phifer

Signature

2/6/20

Date

Jamie Phifer

Print Name

Mission Statement

The Board's mission is to protect the public's health, safety and welfare by regulating the practice of medicine, thereby ensuring quality health care for the citizens of this state.

Payment of your License is Acknowledged.

Jamie Michele Phifer, MD

[redacted]

This is your Licensure Card for the Current Year.

LICENSE TO PRACTICE MEDICINE

LICENSE NO. 02/06/2020-8/25/2020

The State Board of Medicine
hereby certifies that

Jamie Michele Phifer, MD

is duly licensed for the period designated hereon and is entitled to practice medicine in the State of North Dakota during this time.

LICENSE HOLDER

EXECUTIVE SECRETARY

To use the license as a Pocket Card, cut on dotted line and laminate if desired.

MEDICAL LICENSE ISSUANCE INFORMATION

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

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

National Provider Identifier Number 1154615185

Medical Board Name North Dakota Board of Medicine

Member Board License Number 16347

Date License Issued 02/06/2020 (mm/dd/yyyy)

Date of Expiration 08/25/2020 (mm/dd/yyyy)

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

Member Board Signature DocuSigned by: Lynette McDonald E0437FA9DF8747E...

Type Name Lynette McDonald

DATE 2/6/2020 | 9:23 PST

PHYSICIAN'S CORE DATA SHEET

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

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

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

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

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

Date of Birth [redacted] (mm/dd/yyyy) Gender: Male Female X

Physician's office or practice telephone number of public record [redacted] (###-###-####)

Physician's cellular or alternative telephone number [redacted] (###-###-####)

Email address delegated by applicant to receive correspondence [redacted]

Social Security Number: [redacted] ##-##-#

Physician's National Provider Identifie[redacted]

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

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

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

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

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

Residency Program Swedish Cherry Hill Family Medicine
Full Program Name (no abbreviations or acronyms)

Completion Date 06/24/2014 (30)
(mm/dd/yyyy)

What is the specialty of the program Family Medicine

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

Number of attempts taken to pass the USMLE:

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

Number of attempts taken to pass the COMLEX:

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

Number of attempts taken to pass other licensing exam:

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

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

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

Expiration of Specialty Board Certification:

Lifetime:

Time limited: X Expiration date of time limited MOC 3/15/20 ~~06/25/2024~~
(mm/dd/yyyy)

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

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

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

Thank you for applying through the Interstate Medical Licensure Compact.

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

FOR USE OF STATE OF PRINCIPAL LICENSE

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

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

Type Name Kimberly M Romero

Title Licensing Manager

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

CORE DATA CORRECTION SHEET

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

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

Letter of Qualification

IS THIS A RE-APPLICATION? YES NO X

Date 11/19/2019
mm/dd/yyyy

Name: Jamie Michele Phifer

Address: 701 5th Ave Ste 2300

CityStZip Seattle WA 98104-7041

Dear Dr. Phifer:

RE: Your application for IMLC Letter of Qualification

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

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

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

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

Authorized Signature from SPL DocuSigned by: Kimberly M Romero A9E71BFB17A64C1...

Type Name Kimberly M Romero

Title of Authorized SPL Licensing Manager

DATE 11/19/2019 | 8:57 CST

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

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

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

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

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

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

DocuSigned by:

Physicians Signature Jamie Michele Phifer

59A38FF83913468...

Type Physician's Name Jamie Michele Phifer

Applicant's NPI 1154615185

DATE 2/5/2020 | 3:48 CST

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

Thank you for applying through the Interstate Medical Licensure Compact.

All fees are non-refundable

ch_1G8vevJl1O8IBBVti81uGJ6V

Letter of Qualification Verification

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

(Board) IMLCC

DocuSigned by:
Marschall S. Smith
382E3[illegible]4C253468
Signature

David Clark
Type Name

Customer Liaison Manager
Title

2/5/2020 | 4:25 CST
Date

QUALIFICATIONS APPLICATION

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

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

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

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

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

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

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

      If yes, provide the following:

      Residence Street address _____

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

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

      If yes, describe your current practice _____

      _____

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

      If Yes, Employer name 98point6

      Employer street address 701 5th Ave STE 2300

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

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

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

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

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

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

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

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

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

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

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

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

DocuSigned by:
Physician's Signature: Jamie Michele Phifer
59A38FF83913468...

Type Name: Jamie Michele Phifer

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

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

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

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

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

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

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

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

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

Applicant Signature DocuSigned by: Jamie Michele Phifer 59A38FF83913468...

Type Applicant's Name Jamie Michele Phifer

Applicant's NPI 1154615185

DATE 10/10/2019 | 5:56 CDT

MEDICAL LICENSE ISSUANCE INFORMATION

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

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

National Provider Identifier Number 1154615185

Medical Board Name Arizona Medical Board

Member Board License Number 60032

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

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

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

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

Type Name Mary Dunavant

DATE 11/20/2019 | 12:54 CST

MEDICAL LICENSE ISSUANCE INFORMATION

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

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

National Provider Identifier Number 1154615185

Medical Board Name Colorado Medical Board

Member Board License Number CDR.0000560

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

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

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

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

Type Name Shannon Davidson

DATE 11/20/2019 | 10:32 CST