telnet (GothomCity)

```
                    AAAAAA      SSSSSS     IIIIIIIIIII
                   AAAAAAA    SSS  SSS    IIIIIIIIIII



                    AAAAAA      SSSSSS     IIIIIIIIIII
                   AAAAAAA    SSS  SSS    IIIIIIIIIII
                  AAAAAAAA   SSS    SSS       III
                 AAAA AAAA   SSS              III
MEDICAL BOARD                ASSESSMENT SYSTEMS, INC.                    07-08-02
bje1303                           REAL SYSTEM            V2.5.74        02:34:52 PM
INDIVIDUAL NAME                    (JR,SR,III)          REFERENCE # ML20006659
   LAST KRYSZCZUK                                       SOC SEC NUM [22 Licensee SSN]
  FIRST KATHERINE                  +-ADDITIONAL INFORMATION-----------------+
 MIDDLE A                          |          SEX F =      MARRIED Y =       |
                                   |                                         |
RESIDENCE INFORMATION               |   OTHER NAME                          |
VALLEY MEDICAL CENTER               |CORP. OFFICER                        =  |
FAMILY PRACTICE RESIDENCY           |TRUST ACCOUNT                          |
3915 TALBOT RD SOUTH #401           |                                       |
RENTON, WA 98055                    |  BIRTH PLACE ILLINOIS                 |
                                    |        DATE 04-06-1973                |
PHONE: (   )     -      COUNTY:  17 |                                       |
       (   )     -      LGL ST: WA  |SCHOOL CODE                            |
                                    |   CE UNITS    0.00 REQD BY   -   -    |
NOTES                               +-----------------------------------------+

+-------------------------------------------------------------------------+
|CURRENT STATUS: A    EXPIRATION DATE: 07-31-2002  FIRST ISSUE DATE: 06-21-2000|
|RENEWAL STATUS: M   LAST ACTIVE DATE:   -  -     LAST RENEWAL DATE: 07-05-2001|
|COMPLAINTS O/C:  0/ 0      AUTHORITY: RE                                 |
+-------------------------------------------------------------------------+
1GO BACK  2NAM&ADDR 3EDUCATE  4LIC FUNC 5INVESTG  6         7OTHR DAT 8EXTD NOT
```

DEFICIENCY LETTER LOG SHEET

ITEM	Calendar Date	Julian Date
Application Received		
Deficiency Letter 1	JUL 09 2002	
Deficiency Letter 2		
Deficiency Letter 3		
Deficiency Letter 4		
Deficiency Letter 5		
Deficiency Letter 6		
Deficiency Letter 7		
Deficiency Letter 8		
Deficiency Letter 9		
Deficiency Letter 10		
Deficiency Letter 11		
Deficiency Letter 12		
Deficiency Letter 13		
Deficiency Letter 14		
Deficiency Letter 15		
Deficiency Letter 16		
Deficiency Letter 17		
Deficiency Letter 18		
Deficiency Letter 19		
Deficiency Letter 20		

DATE	TELEPHONE LOG	INITIALS

Medical Quality Assurance Commission
Physician Application Worksheet

Pending Number _____
License Number _____

Name KRYSZCZUK, KATHERINE Date of Birth 4/6/1973

Date Received 7/3/2002 Date Complete _____ Signature _____

[ ] Fee [X] Photo [x] Personal Dat [X] AIDS [X] Affidavit [X] SSN [ ] Archive File

Chronology Complete [ ] Missing: _____ to _____, _____ to _____, _____ to _____

[ ] Temporary Permit Requeste _____ Status

FSMB [redacted] AMA [redacted] ECFMG [ ] Reinstatement [ ]

Personal Data Questions	Documentation Received	Malpractice Cases	Original Synopsis	Complair	Disposition
		1			
		2			
		3			
		4			

Medical School Name NORTHWESTERN Year of Degre 2000 [X] U.S. [ ] Canadian [ ] International

07/03/02 Transcripts [ ] Translations

Examination Type [ ] National Boar [ ] FLEX [X] USMLE [ ] State Exan [ ] LMCC [redacted] Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Graduate Training Programs	Accrediation Verified
6/28/02	FAMILY PRACTICE 8/00-6/02				

[ ]		[ ]	
[ ]		[ ]	
[ ]		[ ]	
[ ]		[ ]	
[ ]		[ ]	
[ ]		[ ]	
[ ]		[ ]	

Approved Signature Helen A Lee 7/29/02

Comments:

5 00 C 1 0252140000 ML20006659 A 05-28-02 00022500

NOTICE TO RENEW
RETURN WITH PAYMENT

Washington State Department of Health

PAYABLE IN U.S. FUNDS

DUE DATE	AMOUNT DUE
07-31-02	$ 100.00
PAY LATE AMOUNT BELOW IF PAID AFTER	
07-31-02	$ [illegible]

IF NAME OR ADDRESS IS INCORRECT, PLEASE CORRECT ON REVERSE SIDE. NAME CHANGE INFORMATION MUST BE ACCOMPANIED BY OFFICIAL DOCUMENTATION.

PHYSICIAN

RESIDENT

KATHERINE A. KRYSZCZUK
VALLEY MEDICAL CENTER
FAMILY PRACTICE RESIDENCY
3915 TALBOT RD SOUTH #401
RENTON, WA 98055

Continuing Education is NOT required for renewal.

5 00 C 1 0252140000 ML20006659 A 05 28 02 00022500

COMPLETE THE AFFIDAVIT BELOW **ONLY** IF THE REVERSE SIDE OF THE CARD STATES YOUR CONTINUING EDUCATION IS DUE.

I hereby certify that I have met all requirements for continuing education and have documentation which I will furnish upon request.

Number of Continuing Education Hours_____ Date_____

Signature_____

It is a violation of law to practice without a current license and subject to disciplinary action. In order to avoid a lapse in your license status, please return immediately.

001649 07/16/2002 10000

COMPLETE THIS SECTION **ONLY** IF NAME OR ADDRESS ON THE REVERSE SIDE IS **INCORRECT** OR IF YOU WISH TO CHANGE THE ADDRESS OF RECORD. NAME CHANGE INFORMATION MUST BE ACCOMPANIED BY **OFFICIAL DOCUMENTATION**.

NAME	
STREET	APT
CITY	
STATE	ZIP
COUNTY	TELEPHONE (DAY)

RETURN THIS CARD WITH FEE PAYABLE IN U.S. FUNDS TO: **WASHINGTON DEPARTMENT OF HEALTH**
HEALTH PROFESSIONALS QUALITY ASSURANCE
PO BOX 1099, OLYMPIA WA 98507-1099
IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR CUSTOMER SERVICE CENTER AT (360) 236-4700

(R 2/02)

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4785
(360) 236-4784

FOR OFFICE USE ONLY	
ISSUANCE DATE	
LICENSE #	41491

LICENSE #

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

☐ National Boards ☐ Other State Exam ☐ LMCC (must have been obtained after 1969)
☐ FLEX Examination ☒ USMLE Examination

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL
KRYSZCZUK	KATHERINE	A

ADDRESS: 23915A Talbot Rd S Ste 401

CITY	STATE	ZIP	COUNTY
Renton	WA	98055	USA

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	SOCIAL SECURITY NUMBER
(425) 656 4224	22 Licensee SSN

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
☒ Female ☐ Male	04/06/1973	ILLINOIS

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

Have you ever been known under any other name(s)? ☐ Yes ☒ No

If yes, list name(s):

HEIGHT	WEIGHT
5' 6"	175 lbs
EYE COLOR	HAIR COLOR
Hazel	Blonde

MEDICAL SCHOOL	YEAR OF GRADUATION
NORTHWESTERN UNIVERSITY MEDICAL SCHOOL	2000

MEDICAL SPECIALITY: FAMILY PRACTICE

6/12/02

2. PERSONAL DATA QUESTIONS

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒
"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.		
1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).		
1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.		
(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)		
2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒
"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.		
"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.		
3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☒
4. Are you currently engaged in the illegal use of controlled substances?	☐	☒
"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.		
"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.		
If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.		
5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☒
b. a charge of a sex offense?	☐	☒
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☒
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☒
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☒
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☒
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☒

2. PERSONAL DATA QUESTIONS (continued)

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

3. EDUCATION AND EXPERIENCE

Provide a chronological listing of your educational preparation and post-graduate training.
(Attach additional 8 1/2 X 11 sheets if necessary.)

Schools Attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Number of Years Attended	Dates Attended From (mo/yr)	Dates Attended To (Mo/Yr)	Diploma or Degree Obtained (Quote titles in original language and translate to English.)
Medical Education (List all Medical Schools Attended)				
NORTHWESTERN UNIVERSITY MEDICAL SCHOOL	5	06/95	06/00	MD
Post-Graduate Training (List all Programs Attended)				
VALLEY MEDICAL CENTER FAMILY PRACTICE RESIDENCY	2	06/00	Present	

4. PROFESSIONAL EXPERIENCE

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

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

5. HOSPITAL PRIVILEGES

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

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	DATES Beginning (mo/yr)	DATES Ending (mo/yr)

6. LICENSES IN OTHER STATES

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

State, County or Province	Date License Issued	License Number	Basis of Licensure		Status of License Active or Inactive	Any Limitations on License
			Examination (Date Passed)	Endorsement		

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

Name and Location of Fifth Pathway Program	Name and Location of Hospital	Dates Attended	
		Beginning (mo/yr)	Ending (mo/yr)

8. AIDS AFFIDAVIT

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

Katherine A. Krysczek — APPLICANT'S SIGNATURE

05/29/02 — DATE

9. APPLICANT'S ATTESTATION

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

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

Katherine A. Krysczek — APPLICANT'S SIGNATURE

05/29/02 — DATE

Official Use Only

Washington State Records Center

RECEIVED

JUL 03 2002

Operations and Administration Services

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

US·MLE
United States
Medical
Licensing
Examination™

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 07/22/2002

Washington Medical Quality Assurance Commission
ATTN: Bonnie L. King, Exec Director
PO Box 47866
Olympia, WA 98504-7866

Examinee: Kryszczuk, Katherine Ann
USMLE ID#: 5-024-118-1
DOB: 04 / 06 / 1973
Alt Name(s):

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	6/9/1998	PASS	200	(179)	82	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	12/7/1999	PASS	179	(170)	77	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
WASHINGTON	6/4/2002	PASS	229	(182)	93	(75)	

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

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination scores is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

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

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

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

ANNOTATIONS APPEARING AS "NOTE"

Circumstances <u>not</u> in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are <u>not</u> disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

Washington State Department of Health

MD

REQUEST FOR MEDICAL SCHOOL TRANSCRIPTS

Northwestern University Medical School
UNIVERSITY MEDICAL SCHOOL
303 E. Chicago Ave
ADDRESS
Morton 1-673
Chicago, IL 60611

I am applying for licensure to practice medicine in the state of Washington. Please send a copy of my medical school transcripts (*posted with the MD degree and date granted*) directly to the Washington State Medical Quality Assurance Commission at the address below. Thank you for your assistance.

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

APPLICANT: Please complete the identifying information below to assist the registrar's office in processing your request.

STUDENT NAME: Katherine A. Krysczuk

SSN: 22 Licensee SSN

Kath A. K

YEAR OF GRADUATION: 2000

BIRTHDATE: 04/06/73

Northwestern University
The Feinberg School of Medicine
Transcript

Thursday, June 20, 2002

Studen Kryszczuk, Katherine **SSN:** 22 Licensee SSN **Withdrew:**
Degree: M.D. 02-Jun-00

	Freshman Year		
Fall	1995	Med Decisn Making I	P
Fall	1995	*Patient Perspctives	R
Spring	1996	*Nutrition	R
Spring	1996	Med Decisn Making II	P
Spring	1996	Structure & Function	F
Spring	1996	Patnt/Physn/Socty I	P
Spring	1997	Structure & Function	P
	Sophomore Year		
Spring	1998	Scient Basis of Med	P
Spring	1998	Patnt/Physn/Socty II	P
Spring	1998	Med Decsn Making III	P
	Junior Year		
Summer	1998	Neurology	P
Summer	1998	Psychiatry	H
Fall	1998	Medicine	H
Winter	1999	Multi-Specialty Clerks	P
Winter	1999	Surgery	P
Spring	1999	Obstetrics/Gynecolgy	H
Spring	1999	Pediatrics	P
	Senior Year		
Summer	1999	Family Med - Extrmrl	H
Summer	1999	Primary Care Clrkshp	H
Summer	1999	Diag Radiology NMH	P
Fall	1999	Sr Medicine-EVN	H
Fall	1999	Physical Med & Rehab	H
Winter	2000	Family Med - Extrmrl	H

H - Honors (Jr/Sr only) P - Pass F - Fail W - Withdraw F/P - Pass after Fail C - Credit
DWA - Drop w/o Approval * - Elective I - Incomplete R - Registered F/H - Honors after Pass
This transcript is official only with signature and raised seal.

Miroslava Rachuy
Program Assistant 2
Medical Student Affairs

Health

MD

TO: **Post Graduate Training Program Director**

Valley Medical Center - FP
FACILITY NAME

3915 Talbot Rd So. #201
ADDRESS

Renton, WA. 98055

RE: Verification/Evaluation of Training

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

RECEIVED
JUN 2 2003
Health Professions Section

Katherine Kryszczuk
APPLICANT (PRINT OR TYPE)

04/06/1973
BIRTHDATE

SIGNATURE OF APPLICANT

1. Katherine Kryszczuk is or was engaged in post-graduate training in our program

from 07/00 to 06/03
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

in the field of Family Medicine

2. **At the time this individual was in training, was this program accredited through the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons, or the College of Family Physicians of Canada?** ☒ Yes ☐ No

3. **Briefly evaluate his/her performance, competence and conduct. (Please attach copies of any performance evaluations conducted.)** Satisfactory performance

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

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

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

Return to:
Medical Quality Assurance Commission
1300 SE Quince Street
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(Seal)

Signature
Title Program Director
Hospital Valley Medical Center
PLEASE TYPE OR PRINT
Address 3915 Talbot Rd So #209
Renton, WA. 98055
Date
Telephone (425) 656-4287

DOH 657-034 (Rev 8/2001)

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

July 10, 2002

Attn: Robert Nocoloff
Washington St Bd Osteo Med/Sur
P.O. Box 47870
1300 SE Quince St
Olympia, WA 98504-7870

Re: Board Action Query Dated: July 10, 2002
Your Reference Number:
FSMB Batch Number: BQ688171

The following is a report of the search results from the Board Action Data Bank as of July 10, 2002 for practitioners submitte referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of July 10, 2002

Item	Name	DOB	School	Yr/Grad
3	Hanson, Gwen	10/13/1960	010030	1986
2	Harrell, Thomas	11/23/1964	422010	1998
4	Harvey, Judith	09/17/1962	015010	2000
1	Horton, Curtis	03/17/1972	029010	1998
5	Jordan, Carolyn	04/02/1963	038010	1991
7	Karr, Catherine	12/26/1961	048010	1999
6	Kryszczuk, Katherine	04/06/1973	014060	2000
10	Li, Maria	09/05/1967	064020	1990
12	Licht, Nurit	02/22/1971	030010	1999
11	Lottig, Kristin	11/17/1970	036050	1997
14	Lu, Kimberly	11/30/1973	022020	1995

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Name and Mailing Address:

KATHERINE ANN KRYSZCZUK MD

23 LicenseeAddress

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: UNKNOWN

Birthdate: 04/06/1973
Birthplace: PARK RIDGE, IL UNITED STATES OF AMERICA

Physician's Major Professional Activity: HOSPITAL BASED RESIDENTS - ALL YEARS

Practice Specialties Self Designated by the Physician:

Primary Specialty: FAMILY PRACTICE

Secondary Specialty:

AMA membership: NON MEMBER

Following Data Provided by the Primary Sources

Medical School:

NORTHWESTERN UNIV, THE FEINBERG SCH OF MED, CHICAGO IL 60611 (VERIFIED)

Reported Year of Graduation: 2000 (VERIFIED)

Current and/or Prior Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Institution: VALLEY MED CTR — **State:** WASHINGTON
Specialty : FAMILY PRACTICE — 06/2000 - 06/2003
(BEING REVERIFIED)

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

National Board of Medical Examiners (NBME) Certification Year: NONE REPORTED TO DATE

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

License(s): State	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
WASHINGTON	MD	06/21/2000	07/31/2002	ACTIVE	LIMITED	06/05/2002

Note: **When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.**

ECFMG Certfication:

Applicant Number:

Note: **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 in writing at P.O. Box 13679, Philadelphia, PA 19101.**

Federal Drug Enforcement Administration:

TO DATE, FEDERAL DEA REGISTRATION STATUS IS UNKNOWN.

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

Specialty Board Certification(s):

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

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.

Certificate:

Certificate Type:

Effective: **Expiration:** **Last Reported:**

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

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

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

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Additional Information:

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

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, residency training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please mark them on a copy of the profile and mail or fax to:

Division of Survey and Data Resources
Attn: Physician Profile Unit
515 N. State Street
Chicago, IL 60610
312 464-5199
312 464-5900 (fax)

3915 Talbot Road South, Suite 401
Renton, WA 98055
(425) 656-4224 Clinic
(425) 656-4099 Clinic Fax
(425) 656-4287 Residency Admin.
(425) 656-5395 Residency Fax

Valley Medical Center
Family Practice Residency

June 19, 2002

Department of Health
Medical Quality Assurance Commission
11300 SE Quince Street
P.O. Box 47866
Olympia, WA 98504-7866

To Whom It May Concern:

This is to confirm that **Katherine Kryszczuk, M.D.** is a third year resident with Valley Medical Center's family practice residency for the period of July 1, 2002 through June 30, 2003.

Dr. Kryszczuk has requested her full license be issued with a two year expiration date.

Sincerely,

Andrew B. Oliveira, M.D., MHA
Program Director

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
1300 SE Quince St • P.O. Box 47866 • Olympia, Washington 98504-7866
July 9, 2002

Katherine Kryszczuk MD
3915 Talbot Rd S Suite 401
Renton WA 98055

Dear Dr Kryszczuk

This is to acknowledge receipt of your application to obtain licensure as a physician and surgeon in the state of Washington.

Your application was received on **July 2 2002.**

MISSING ITEM. —
Application Fee
USMLE

A deficiency letter will be sent every four to five weeks until the application is considered complete. Please understand Commission staff process a considerable amount of application files at any given time. Deficiency letters are our way of notifying you what is lacking in your file. An over abundance of phone calls simply slows the process down as it diverts staff resources from application processing. We appreciate your consideration of staff resources and your patience with the process.

If you have any further questions or need additional information, email me at betty.elliott@doh.wa.gov, or write to me at Department of Health, Medical Quality Assurance Commission, P O Box 47866, Olympia, WA 98504-7866.

Sincerely,

Betty Elliott
Licensing Representative

Medical Quality Assurance Commission
Limited License Application Worksheet

Pending Number _____
License Number _____

Name KRYSZCZUK, KATHERINE **DATE OF BIRTH 4/6/1973**

Date Received 05/10/2000 Date Completed _____ Signature _____

$225.00 Fee	X	Photo	X	Personal Data	X	AIDS	X	Affidavit	X	SSN		Archive File

Chronology Complete [ ] Missing: —

[X] Residency [ ] Institution
[ ] Fellowship [ ] City/County
[ ] Teaching/Research

[ ] FSMB
[ ] AMA

Personal Data Questions	Documentation Received

Malpractice Cases

	Synopsis	Original Complaint	Disposition
1			
2			
3			
4			

Medical School Name NORTHERN School Code _____ Year of Degree 2000

[X] U.S. [ ] Canadian [ ] International
[redacted] Transcripts [ ] Translations

Examination Type [ ] National Boards [ ] FLEX [ ] USMLE [ ] State Exam [ ] LMCC [ ] Scores Received

Received	Post Graduate Training Programs	Accrediation Verified	Received	Post Graduate Training Programs	Accrediation Verified

Received	State Licensure	Received	Hospital Privileges

Received	Program/Employment Verification	Received	Program/Employment Verification
5/10/00	VALLEY MEDICAL CENTER 6/21/00		

Approved Susan Boettcher
Signature

7-10-2000
Date

Comments:

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

DEPOSIT CREDIT

Physician & Surgeon

Katherine A. Kryszczuk
NAME (Please Print)

5/12/2000 NW
DATE

DOH 657-079 (2/00)

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

☐ Check ☐ Money Order

$ 225

Please note amount enclosed, and return with your application.

1F 0252090000 00236

001024 05/23/2000 22500

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4785
(360) 236-4784

FOR OFFICE USE ONLY
ISSUANCE DATE
LICENSE # 6059

LICENSE #

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

☐ Teaching-Research (2 year limit) ☒ Internship-Residency ☐ Institution
☐ Fellowship (2 Year Limit) ☐ County-City Health Department

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL
KRYSZCZUK	KATHERINE	A

NAME OF INSTITUTION/HEALTH DEPT/MEDICAL SCHOOL/HOSPITAL
VALLEY MEDICAL CENTER FAMILY PRACTICE RESIDENCY

ADDRESS
3915 Talbot Road South #401

CITY	STATE	ZIP	COUNTY
Renton	WA	98055	USA

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	SOCIAL SECURITY NUMBER
(425) 228-3440 x2568	22 Licensee SSN

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH
☒ Female ☐ Male	04/06/73	ILLINOIS

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

Have you ever been known under any other name(s)? ☐ Yes ☒ No

If yes, list name(s):

HEIGHT	WEIGHT
5' 6"	160 lbs
EYE COLOR	HAIR COLOR
HAZEL	BLONDE

MEDICAL SCHOOL	YEAR OF GRADUATION
NORTHWESTERN UNIVERSITY	2000

MEDICAL SPECIALITY
FAMILY PRACTICE

2. PERSONAL DATA QUESTIONS

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒
"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.		
1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).		
1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.		
(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)		
2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒
"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.		
"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.		
3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☒
4. Are you currently engaged in the illegal use of controlled substances?	☐	☒
"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.		
"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.		
If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.		
5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☒
b. a charge of a sex offense?	☐	☒
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☒
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☒
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☒
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☒
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☒

2. PERSONAL DATA QUESTIONS (Continued)

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

3. EDUCATION AND EXPERIENCE

Provide a chronological listing of your educational preparation and post-graduate training.
(Attach additional 8 1/2 X 11 sheets if necessary.)

Schools Attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Number of Years Attended	Dates Attended From (mo/yr)	Dates Attended To (Mo/Yr)	Diploma or Degree Obtained (Quote titles in original language and translate to English.)
Medical Education (List all Medical Schools Attended) Northwestern University Medical School	5	08/95	06/00	MD
Post-Graduate Training (List all Programs Attended)				

4. PROFESSIONAL EXPERIENCE

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

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

5. HOSPITAL PRIVILEGES

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

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	DATES Beginning (mo/yr)	DATES Ending (mo/yr)

6. LICENSES IN OTHER STATES

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

State, County or Province	Date License Issued	License Number	Basis of Licensure		Status of License Active or Inactive	Any Limitations on License
			Examination (Date Passed)	Endorsement		

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

Name and Location of Fifth Pathway Program	Name and Location of Hospital	Dates Attended	
		Beginning (mo/yr)	Ending (mo/yr)

8. AIDS AFFIDAVIT

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

Katherine A. Kr — APPLICANT'S SIGNATURE

04/25/00 — DATE

9. APPLICANT'S ATTESTATION

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

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

Katherine A. Kr — APPLICANT'S SIGNATURE

04/25/00 — DATE

Northwestern University Medical School Transcript

Monday, June 26, 2000

Student: Kryszczuk, Katherine **SSN:** 22 Licensee SSN **Box** 461
Degree: M.D. 02-Jun-00 **Withdrew:**

	Freshman Year		
Fall	1995	Med Decisn Making I	P
Fall	1995	*Patient Perspctives	R
Spring	1996	*Nutrition	R
Spring	1996	Med Decisn Making II	P
Spring	1996	Structure & Function	F
Spring	1996	Patnt/Physn/Socty I	P
Spring	1997	Structure & Function	P
	Sophomore Year		
Spring	1998	Scient Basis of Med	P
Spring	1998	Patnt/Physn/Socty II	P
Spring	1998	Med Decsn Making III	P
	Junior Year		
Summer	1998	Psychiatry	H
Summer	1998	Neurology	P
Fall	1998	Medicine	H
Winter	1999	Multi-Specialty Clerks	P
Winter	1999	Surgery	P
Spring	1999	Obstetrics/Gynecolgy	H
Spring	1999	Pediatrics	P
	Senior Year		
Summer	1999	Family Med - Extrmrl	H
Summer	1999	Primary Care Clrkshp	H
Summer	1999	Diag Radiology NMH	P
Fall	1999	Sr Medicine-EVN	H
Fall	1999	Physical Med & Rehab	H
Winter	2000	Family Med - Extrmrl	H

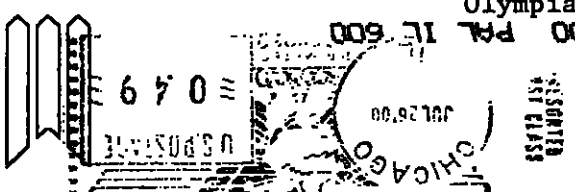
H - Honors (Jr/Sr only) P - Pass F - Fail W - Withdraw F/P - Pass after Fail C - Credit
DWA - Drop w/o Approval * - Elective I - Incomplete R - Registered F/H - Honors after Pass

This transcript is official only with signature and raised seal.

Miroslava Rachuy
Program Assistant 2
Medical Student Affairs

Northwestern University Medical School

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



Office of Student Affairs

Morton 1-673
303 East Chicago Avenue
Chicago, Illinois 60611-3008

Northwestern University Medical School Transcript

Friday, April 28, 2000

Student: Kryszczuk, Katherine **SSN:** 22 Licensee SSN **Box 461**
Degree: **Withdrew:**

	Freshman Year		
Fall	1995	Med Decisn Making I	P
Fall	1995	*Patient Perspctives	R
Spring	1996	*Nutrition	R
Spring	1996	Med Decisn Making II	P
Spring	1996	Structure & Function	F
Spring	1996	Patnt/Physn/Socty I	P
Spring	1997	Structure & Function	P
	Sophomore Year		
Spring	1998	Scient Basis of Med	P
Spring	1998	Patnt/Physn/Socty II	P
Spring	1998	Med Decsn Making III	P
	Junior Year		
Summer	1998	Psychiatry	H
Summer	1998	Neurology	P
Fall	1998	Medicine	H
Winter	1999	Multi-Specialty Clerks	P
Winter	1999	Surgery	P
Spring	1999	Obstetrics/Gynecolgy	H
Spring	1999	Pediatrics	P
	Senior Year		
Summer	1999	Family Med - Extrmrl	H
Summer	1999	Primary Care Clrkshp	H
Summer	1999	Diag Radiology NMH	P
Fall	1999	Sr Medicine-EVN	H
Fall	1999	Physical Med & Rehab	H
Winter	2000	Family Med - Extrmrl	H

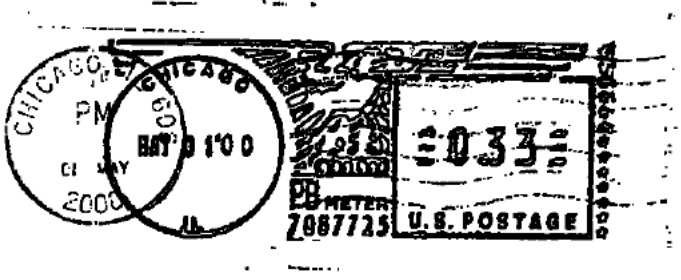
H - Honors (Jr/Sr only) P - Pass F - Fail W - Withdraw F/P - Pass after Fail C - Credit
DWA - Drop w/o Approval * - Elective I - Incomplete R - Registered F/H - Honors after Pass

This transcript is official only with signature and raised seal.

Miroslava Rachuy
Program Assistant 2
Medical Student Affairs

NORTHWESTERN UNIVERSITY MEDICAL SCHOOL

Office of Student Affairs



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

98504-7866

Morton I-673
303 East Chicago Avenue
Chicago, Illinois 60611-3008

Washington State Department of Health
Medical Quality Assurance Commission
1300 SE Quince Street
PO Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Medical Quality Assurance Commission
Residency Certification

This is to certify that Katherine Kryszczuk has been

appointed as a resident* in Family Practice (SERVICE) at

the Valley Medical Center hospital for the period,

beginning June (MONTH) 21 (DAY) 2000 (YEAR). The individual responsible for this resident's

patient care activities will be _____ (SIGNATURE) DIRECTOR OF PROGRAM.

* Resident physician means an individual who has graduated from a school of medicine which meets the requirements set forth in RCW 18.71.095(3) and is serving a period of post graduate clinical medical training sponsored by a college or university in this state or by a hospital accredited by this state. The term shall include individuals designated as intern or medical fellow.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 SE Quince St • P.O. Box 47866 • Olympia, WA 98504-7866

June 7, 2000

Katherine Kryszczuk MD
Valley Medical Center
3915 Talbot Rd South #401
Renton wA 98055

Dear Dr Kryszuzuk

This is to acknowledge receipt of your application to obtain a limited license in the state of Washington.

Your application was received on **May 10, 2000.**

Missing Items: Medical School Transcripts With MD degree

A deficiency letter will be sent every four to five weeks until the application is considered complete. Please understand Commission staff process a considerable amount of application files at any given time. Deficiency letters are our way of notifying you what is lacking in your file. An over abundance of phone calls simply slow the process down as it diverts staff resources from application processing. We appreciate your consideration of staff resources and your patience with the process.

Depending on the complexity of the application file, the review process may take 3 to 5 working days for routine applications, an additional 14 working days for applications considered non-routine that must be reviewed by a Commission Member, or, if your application contains derogatory or disciplinary information, it may need to be reviewed by the Full Commission at a Commission meeting for final disposition, in which case the processing time will be longer.

If you have any questions, please feel free to contact me at (360) 236-4785.

Sincerely,

Betty Elliott
Program Representative