Licensee/Applicant	Declaration Question	Answer	Answer Details	Created On
Anuj KHATTAR	Denied Membership	No		May-10-2021 03:37 PM
Anuj KHATTAR	MD Actively Practiced	No		May-10-2021 03:37 PM
Anuj KHATTAR	Chemical Substances Impair Safe Practice	No		May-10-2021 03:37 PM
Anuj KHATTAR	Hospital Privileges Issues	No		May-10-2021 03:37 PM
Anuj KHATTAR	Drop to Inactive Status	No		May-10-2021 03:37 PM
Anuj KHATTAR	Failed Public Service	No		May-10-2021 03:37 PM
Anuj KHATTAR	Conscious Sedation Attestation	Yes		May-10-2021 03:37 PM
Anuj KHATTAR	Named Defendant Respond to Legal Action	No		May-10-2021 03:37 PM
Anuj KHATTAR	CME Affirmation	Yes		May-10-2021 03:37 PM
Anuj KHATTAR	Denied License / Permission to Practice Medicine	No		May-10-2021 03:37 PM
Anuj KHATTAR	MD - Swear and Affirm	Yes		May-10-2021 03:37 PM
Anuj KHATTAR	Medical Condition Impair Safe Practice	No		May-10-2021 03:37 PM
Anuj KHATTAR	Investigation -- Respond To/Notify Of	No		May-10-2021 03:37 PM
Anuj KHATTAR	Medical Condition Field of Practice	No		May-10-2021 03:37 PM
Anuj KHATTAR	Controlled Substance Registration	No		May-10-2021 03:37 PM
Anuj KHATTAR	Suicide CME Attestation	Yes		May-10-2021 03:37 PM
Anuj KHATTAR	Medical License Revoked	No		May-10-2021 03:37 PM
Anuj KHATTAR	Malpractice Claim Paid	No		May-10-2021 03:37 PM
Anuj KHATTAR	Arrest Question	No		May-10-2021 03:37 PM
Anuj KHATTAR	Voluntarily Surrendered a License	No		May-10-2021 03:37 PM

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive Reno, Nevada 89521 Phone (775) 688-2559

RECEIVED
SEP 14 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Licensee Name: ANUJ KHATTAR
(Please print and indicate your legal name)

Licensee Public Address: 4220 South Othello St. ✓

City, State, Zip: Seattle WA 98118 ✓

Direct Contact Telephone Number: ✓

Direct Contact Electronic Mail Address: ✓

Attestations/Affirmations:

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

✓ (a) I am not subject to a court order for the support of a child;

______ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

______ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. ✓ Yes ______ No

http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. ✓ Yes ______ No

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States.

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

RECEIVED
SEP 14 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Printed Name of Applicant/Licensee: ANUJ KHATTAR

Signature of Applicant/Licensee: ____________________

Electronic Mail Address: ____________________

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? ____Yes ✓ No

If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

2-If yes, which branch of service did you serve?

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard

3-Military occupation specialty or specialties?

- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

4&5-Dates of service in the Military: 4-From: ____/____/____ (DD MM YYYY) 5-To: ____/____/____ (DD MM YYYY)

6-Are you still serving? ____Yes ____ No

7-Have you ever served on active duty in the Armed Forces of the United States? ____Yes ____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? ____Yes ____No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? ____Yes ____No

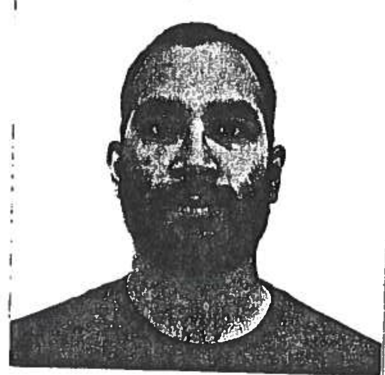
10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged your answer should be "yes.") ____Yes ____No ____N/A

RECEIVED
SEP 14 2020
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

LICENSEE PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY
OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST
SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.



I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

Signature of Licensee ______________________ Date 9/9/2020

Letter of Qualification

IS THIS A RE-APPLICATION? YES NO x

Date 08/11/2020
mm/dd/yyyy

Name: Anuj none Khattar

Address: 4220 S Othello St

CityStZip Seattle, WA 98118

Dear Dr. Khattar:

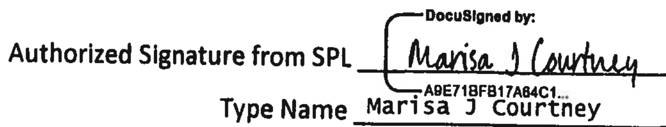
RE: Your application for IMLC Letter of Qualification

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

Type Name Marisa J Courtney

Title of Authorized SPL Licensing Manager

DATE 8/11/2020 | 5:09 CDT

PHYSICIAN'S CORE DATA SHEET

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

Full Legal Name Anuj, NONE, Khattar, ____
(Exactly as on DL or Passport) First Middle Last Suffix(Sr., Jr.)

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

Mailing address 4220 South Othello St ____, Seattle, WA, 98118
Mailing address City State(XX) Zip

Office address 263 Rainier Ave S, Unit #200, Renton, WA, 98057
Office address City State(XX) Zip

Date of Birth /1985
(mm/dd/yyyy)

Gender: Male x Female

Physician's office or practice telephone number of public record 425-255-0471
(###-###-####)

Physician's cellular or alternative telephone number ____
(###-###-####)

Email address delegated by applicant to receive correspondence ____

Social Security Number: ____
(###-##-####)

Physician's National Provider Identifier Number ____

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 Oregon Health and Science University
Name of School (no abbreviations or acronyms)

Date of Degree Issued 06/04/2012
(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 Family Medicine, Cherry Hill
Full Program Name (no abbreviations or acronyms)

Completion Date 06/24/2015
(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: Family Medicine
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

In Process

Lifetime:

Time limited: x Expiration date of time limited 12/31/2025
(mm/dd/yyyy)

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

License # MD60465043 Date of Original Licensure 06/20/2014 (not renewal)
(mm/dd/yyyy)

Expiration Date 09/14/2021 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: Marisa J Courtney A9E71BFB17A64C1...

Type Name Marisa J Courtney

Title Licensing Manager

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

DocuSign Envelope ID: 6779A969-9E6B-4A15-B[illegible]7849E6880EB

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
MOC	12/31/2025	02/15/2021

In Process

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? MD60465043

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 X No

   If yes, provide the following:

   Residence Street address ________

   Residence City State Zip Seattle (City), WA (St), 98118 (Zip)

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

   If yes, describe your current practice Family Medicine and reproductive health clinics

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

   If Yes, Employer name Cedar River Clinics

   Employer street address 263 Rainier Ave S, Unit #200

   Employer City State Zip Renton (City), WA (St), 98057 (Zip)

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

   If yes, give Tax ID # (SS#, EIN) 594366618 (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

---

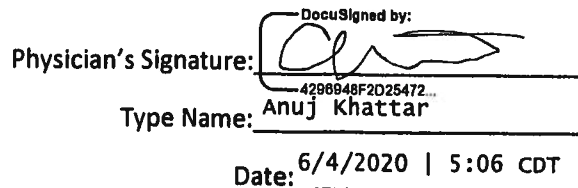
(Please note that answering any of the following questions with a "YES" will result in your application being denied per eligibility Rule 5.4. If eligibility is in question please contact the state board directly for information regarding application through the traditional method.)

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

Physician's Signature: 

Type Name: Anuj Khattar

Date: 6/4/2020 | 5:06 CDT

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

I, Anuj Khattar (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.

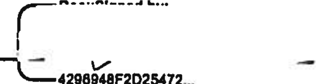
I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement 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



Type Applicant's Name Anuj Khattar

Applicant's NPI 1841550712

DATE 6/4/2020 | 5:06 CDT

In Process