



ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

Emails with attachments must be sent in PDF format to support@armedicalboard.org

Are you utilizing FCVS for your Arkansas license? Yes No

Are you a current or former member of the U.S. military or a spouse of a current or former member of the U.S. military? Yes No

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS & Centralized Credentials Verification Service

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

TYPE OF LICENSE YOU ARE APPLYING FOR (check one)

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

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

PART I - PERSONAL IDENTIFICATION INFORMATION

1a. Full Legal Name (Last, First, Middle, Suffix, Degree)

Jackson, Quinn, Michelle

1b. Other Names Used (including Maiden Name)

none

2a. Social Security Number

2b. Driver's License State & Number

NM

2c. Gender

Male Female

2d. Date of Birth (mm/dd/yyyy)

3a. Place of Birth

Newport Beach, CA

3b. Country of Citizenship

USA

3c. Immigration Status (if not U.S. citizen)

N/A

3d. How long have you been in the U.S.? (if not U.S. citizen)

N/A

3e. Ethnicity Non-Hispanic Hispanic

3f. Race American Indian/Alaska Native Asian
 Black/African American White Hawaiian/Pacific Islander
 Hispanic

4a. Public Address (Street, City, State, Zip Code)

4401 W 109th St #100, Overland Park, KS, 66211

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

Albuquerque, NM 87110

4c. Private Phone #

4d. Work Phone #

N/A

4e. Fax #

none

4f. Mobile Phone #

none

4g. Personal E-mail Address

5a. If not currently living in Arkansas, do you plan to relocate?

No Yes - Approx. date: _____

5b. Intended Practice Location in Arkansas: Name and Address of Hospital, Clinic, Group or Private Practice

Planned Parenthood Great Plains, Little Rock, AR

5c. Will you be providing telemedicine services from outside the state of Arkansas?

No Yes - Name of Telemedicine Contract Firm: _____

Phone _____

6a. NPI Number

6b. Accept Medicaid/Medicare Patients?

Medicare Medicaid Neither Unknown/Undecided

FOR ASMB USE ONLY

Name Quinn Michelle Jackson M.D.

Application Received 2/3/2020

License Number _____

Fees Received \$ 500.00

License Issued _____

Application Declined _____

Basis for License USMLE

PHIDNo. ASMB216928

PART II - EDUCATION

MEDICAL SCHOOL EDUCATION

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

7a. Institution Name <i>Tulane University School of Medicine</i>	7b. Country of Medical School <i>USA</i>
---	---

7c. Mailing Address (Street Address, City, State/Country, Zip Code) <i>1430 Tulane Ave, New Orleans, LA, 70112</i>

7d. Start Date <i>06/1/2013</i>	7e. End Date <i>05/20/2017</i>	7f. Graduated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	7g. Degree Awarded <input checked="" type="checkbox"/> M.D. (or foreign equivalent) <input type="checkbox"/> D.O. <input type="checkbox"/> None
------------------------------------	-----------------------------------	---	--

8a. Institution Name <i>N/A</i>	8b. Country of Medical School
------------------------------------	-------------------------------

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

8d. Start Date <i>/ /</i>	8e. End Date <i>/ /</i>	8f. Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> No	8g. Degree Awarded <input type="checkbox"/> M.D. (or foreign equivalent) <input type="checkbox"/> D.O. <input type="checkbox"/> None
------------------------------	----------------------------	--	---

POSTGRADUATE EDUCATION, US OR FOREIGN

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

9a. Full Name of Training Program <i>University of New Mexico</i>	9b. Program ID (if known) <i>unknown</i>
--	---

9c. Program Type (Internship, Residency, etc) <i>Internship/Residency</i>	9d. Specialty/Subspecialty <i>Family Medicine</i>	9e. Department Name <i>Family and Community Medicine</i>
--	--	---

9f. Mailing Address (Street Address, City, State/Country, Zip Code) <i>MSC 09-5040, University of New Mexico, Albuquerque, NM, 87110</i>

9g. Start Date <i>07/01/2017</i>	9h. End Date <i>N/A / /</i>	9i. Anticipated End Date <i>06/30/2020</i>	9j. Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> In Process	9k. Chief resident? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
-------------------------------------	--------------------------------	---	--	--

9a. Full Name of Training Program <i>N/A</i>	9b. Program ID (if known)
---	---------------------------

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

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

9g. Start Date <i>/ /</i>	9h. End Date <i>/ /</i>	9i. Anticipated End Date <i>/ /</i>	9j. Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Process	9k. Chief resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
------------------------------	----------------------------	--	---	---

9a. Full Name of Training Program <i>N/A</i>	9b. Program ID (if known)
---	---------------------------

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

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

9g. Start Date <i>/ /</i>	9h. End Date <i>/ /</i>	9i. Anticipated End Date <i>/ /</i>	9j. Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Process	9k. Chief resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
------------------------------	----------------------------	--	---	---

9a. Full Name of Training Program <i>N/A</i>	9b. Program ID (if known)
---	---------------------------

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

9f. Mailing Address (Street Address, City, State/Country, Zip Code) <i>73411, S-114 8017</i>

9g. Start Date <i>/ /</i>	9h. End Date <i>/ /</i>	9i. Anticipated End Date <i>/ /</i>	9j. Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Process	9k. Chief resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
------------------------------	----------------------------	--	---	---

EXAMINATION HISTORY		Please specify exam series USMLE, NBME, FLEX, NBOME, COMLEX, LMCC (or State Exam prior to 1975). If you failed any step of any examination, even once, you must submit a separate, signed and dated explanation of the circumstances. Attach additional sheets if necessary.		
10a. Exam Series & Step USMLE Step 1	10b. Number of Attempts one	10c. Number of times failed zero	10d. Date PASSED 04/16/2015	
10a. Exam Series & Step USMLE Step 2 CK	10b. Number of Attempts one	10c. Number of times failed zero	10d. Date PASSED 05/24/2016	
10a. Exam Series & Step USMLE Step 2 CS	10b. Number of Attempts one	10c. Number of times failed zero	10d. Date PASSED 05/12/2016	
10a. Exam Series & Step USMLE Step 3	10b. Number of Attempts one	10c. Number of times failed zero	10d. Date PASSED 06/15/2018	
10e. Have you ever taken the SPEX or COMVEX examination? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, you must provide a signed and dated explanation.				
11a. If you are an international medical graduate, do you hold an ECFMG certification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (If No, you must provide a signed and dated explanation)		11b. ECFMG Certificate No. N/A		11c. Date Issued / /
SPECIALTY/ BOARD CERTIFICATION		Please list all specialties, including self-designated. Attach additional sheets if necessary.		
12a. Primary Practice Specialty/Subspecialty Family medicine	12b. Board Certified? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	12c. Certification Type <input type="checkbox"/> Lifetime <input type="checkbox"/> Time-Limited <input type="checkbox"/> MOC		
12d. Name of Specialty Board, if certified	12e. Certification Date / /	12f. Recertification Date / /	12g. Expiration Date / /	
13a. Secondary Specialty/Subspecialty	13b. Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	13c. Certification Type <input type="checkbox"/> Lifetime <input type="checkbox"/> Time-Limited <input type="checkbox"/> MOC		
13d. Name of Specialty Board, if certified	13e. Certification Date / /	13f. Recertification Date / /	13g. Expiration Date / /	
14a. Tertiary Specialty/Subspecialty	14b. Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	14c. Certification Type <input type="checkbox"/> Lifetime <input type="checkbox"/> Time-Limited <input type="checkbox"/> MOC		
14d. Name of Specialty Board, if certified	14e. Certification Date / /	14f. Recertification Date / /	14g. Expiration Date / /	
PART III - PROFESSIONAL ACTIVITIES				
PROFESSIONAL LICENSURE		List all states or territories of the United States or other countries in which you hold or have ever held a medical license. Include all temporary, instructional and training permits/licenses. Attach additional sheets if necessary. If none, enter "N/A."		
15a. Jurisdiction (State, Country) New Mexico, USA	15b. License No. MD2019-1060	15c. Issue Date 12/12/2019	15d. Expiration Date 07/01/2022	15e. Current Status Active
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date / /	15d. Expiration Date / /	15e. Current Status
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date / /	15d. Expiration Date / /	15e. Current Status
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date / /	15d. Expiration Date / /	15e. Current Status
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date / /	15d. Expiration Date / /	15e. Current Status
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date / /	15d. Expiration Date / /	15e. Current Status
15a. Jurisdiction (State, Country)	15b. License No. 28-1111	15c. Issue Date 6-13-2007	15d. Expiration Date / /	15e. Current Status
15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date / /	15d. Expiration Date / /	15e. Current Status

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

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

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

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

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

17a. Date From N/A / /	17b. Date To / /	17c. Type of Affiliation, (Primary or Previous Practice, Employment, Staff Appointment, etc.)
---------------------------	---------------------	---

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2023 FEB - 6 11:27

RECEIVED
ASIM

WORK HISTORY, continued

17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		<input type="checkbox"/> Primary Practice <input type="checkbox"/> Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		<input type="checkbox"/> Primary Practice <input type="checkbox"/> Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		<input type="checkbox"/> Primary Practice <input type="checkbox"/> Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		<input type="checkbox"/> Primary Practice <input type="checkbox"/> Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		<input type="checkbox"/> Primary Practice <input type="checkbox"/> Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
17d. Name of Institution/Facility		<input type="checkbox"/> Primary Practice <input type="checkbox"/> Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)		
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in

RECEIVED - 3 APR 22

RECEIVED
ASHP

FEDERAL DEA & STATE- ISSUED CONTROLLED SUBSTANCE REGISTRATIONS List all current and previous Federal DEA and state-issued controlled substance registrations. If none, enter N/A.

18a. DEA or State Registration # N/A	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /
18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date / /

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

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

19b. Dates of time gap

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

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

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

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

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

2022 FEB - 3 11:22 AM

RECEIVED

PART IV - ATTESTATION QUESTIONS

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

SPECIAL INSTRUCTIONS FOR QUESTIONS 22-44

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

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

22-1117 3-2019

RECEIVED
MAY 15 2019

PART IV - ATTESTATION QUESTIONS, continued

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

2020 FEB -9 AM 11:22

RECEIVED
ASMP

PART V - AFFIDAVIT OF APPLICANT

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



[Handwritten Signature]

Applicant's Signature (in ink)

(must be signed in the presence of a Notary Public)

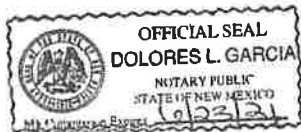
01/28/2020

Date Signed

(must include the month, day and year signed)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the State of New Mexico, this 28 day of January, 20 20.
(Notary date must be the same as the applicant's signature date above)

My commission expires: 6/23/21



[Handwritten Notary Signature]

Notary Signature

(Notary seal must be below the photograph at left)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

2020 FEB - 3 AM 11:22

RECEIVED

PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board As of Date: 2/4/2020
Practitioner Name: Jackson, Quinn Michelle

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

ENTERED
FEB 8 5 2020

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

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

Instruction to the Dean

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

**Federation Credentials
Verification Service**
400 Fuller Wisser Road
Suite 300
Euless, TX 76039

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

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

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Tulane University School of Medicine

Address Line 1: 1430 Tulane Avenue, #8025

Address Line 2:

City: New Orleans

State/Province: LA

Zip Code (Postal Code): 70112

Country: US

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

N/A

Premedical Education:

Years of education required for admission to your medical school: 4

Credential/degree presented by the applicant for admission to your medical school: College degree

Enrollment and Participation: Our records indicate that Jackson, Quinn Michelle

(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 4 years of medical education on the following dates: **From:** 08/05/2013 **To:** 05/19/2017
Month Day Year Month Day Year

This individual

Was awarded the degree of Doctor of Medicine on 05/20/2017

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

<p>Attestation</p> <p>Affix Institutional Seal Here</p> <hr/> <p>If no seal is available, this form must be notarized.</p>	<p>Watermark For FCVS internal use only</p> <p>ELECTRONIC SEAL VERIFIED</p>	<p>Name: Joell Lee</p> <p>Signature: <i>Joell Lee</i></p> <p>Title: Program Manager, II</p> <p>Date of Signature: 10/23/2019 Phone: (504) 988-5464</p> <p>Fax: (504) 988-6789 Email: joell@tulane.edu</p>
---	--	--

300778461

1583

300778461

Unusual Circumstances

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

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

From Date: To Date:

- Personal/Family _____
- Academic remediation _____
- Health _____
- Financial _____
- Participation in joint degree Program (e.g., MD/PhD)
- Participation in non-research special study
(e.g., fellowship, international experience) _____
- Participation in non-degree research _____
- Other:
- Other:
- Please Specify:

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

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

From Date: To Date:

- Academic Probation _____
- Probation for unprofessional conduct/behavioral _____
- Other:
- Please specify a reason:

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

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

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

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

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? No

If YES, please provide detailed documentation/information about the nature of the limitations or special requirement:

Medical School

Medical Professional Name: Jackson, Quinn Michelle

Tulane University School of Medicine

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

End of Applicant Reported Unusual Circumstances report for: Jackson, Quinn Michelle



SCHOOL OF MEDICINE

Marc J. Kahn, MD, MBA
Senior Associate Dean for Admissions and Student Affairs
Professor of Medicine

MEDICAL STUDENT PERFORMANCE EVALUATION

For

Quinn M. Jackson

October 2016

IDENTIFYING INFORMATION

Quinn Jackson is a fourth year student at the Tulane University School of Medicine in New Orleans, Louisiana.

UNIQUE CHARACTERISTICS

Quinn Jackson is the daughter of Stephen Jackson, who works in information technology and Alison Jackson, a librarian. Quinn completed her undergraduate studies at the University of Florida, earning her Bachelor of Arts in Women Studies in 2011. Quinn graduated *Cum Laude* and began working for Planned Parenthood of North Florida as an undergraduate. Quinn received a travel grant as an undergraduate, to go to India to take courses on gender roles in agriculture politics and religion. Following college, Quinn spent two additional years working for Planned Parenthood of North Florida. Quinn will receive her M.D. in addition to her Masters of Public Health in Global Community Health and Behavior upon graduation this year. As a medical student, Quinn has served as President of Tulane's chapter for Medical Students for Choice. She has also been put on the National Board of Directors for that organization. Quinn has been an officer of the Obstetrics and Gynecology Interest Group. Quinn has volunteered in the New Orleans community, volunteering at a local facility for recovering substance abusers and at a local women's shelter. Quinn has been a student leader for the Tulane Sexual Health elective. Quinn has been part of the rural immersion program, spending several of her core rotations: family, medicine, pediatrics, OB/GYN and surgery in a rural setting in Louisiana. Quinn was a member of the Society of Family Planning, the Association of Reproductive Health Professionals and the American Academy of Family Physicians.

Health Sciences Center

1430 Tulane Ave., #8010, New Orleans, LA 70112 tel 504.988.5331 fax 504.988.6462 www.tulane.edu

ACADEMIC HISTORY

Date of Initial Matriculation into Medical School: August 2013
Date of Expected Graduation from Medical School: May 2017

Quinn Jackson completed the Medical School curriculum without any extensions, leaves of absence, gaps or breaks in her educational program.

Was the student required to repeat or otherwise remediate any course work during her medical education? **No**

Was the student the recipient of any adverse action(s) by the medical school or its parent institution? **No**

ACADEMIC PROGRESS

Pre-clinical/basic science curriculum

The Tulane University School of Medicine grades the preclinical courses on a Pass/Fail basis only. Quinn Jackson successfully passed all of her preclinical courses.

Required Clinical Clerkships Record

The following are representative faculty comments from the required clerkships taken to date. They are not listed in the order taken by the student. Pass grades were achieved unless otherwise noted in the clerkship comments.

Surgery: Quinn Jackson performed the General Surgical Clerkship. Faculty evaluators commented that she was an excellent medical student who showed keen interest and was on top of things. This student rotated on the General Surgery service, as well as the General Surgery/Oncologic services where it was commented that Quinn was remarkably enthusiastic and eager. She typically extended beyond what was required in regards to patient care and responsibilities. She readily accepted responsibility and usually was asking for more. She will be an excellent physician. Quinn's fund of knowledge, clinical acumen, H & P's, presentations, technical skills, appearance and demeanor, as well as patient records and documentation were all satisfactory to her level of training

Medicine: Very easy to work with. Did a good job synthesizing patient information and presenting during rounds. I had Quinn for just a few days so difficult to evaluate, but my fellow told me she was an excellent student. Quinn was fantastic. I think she'll do well in whatever field she pursues. Her presentations were very well done and she always knew what was going on with her patients. It was a pleasure to have Quinn on service. She was extremely helpful to the residents which is what I value most. She has above average level of curiosity and clinical acumen at this level of training. I look forward to observing her transition from manager to educator of her peers.

Obstetrics and Gynecology: HONORS Quinn Jackson performed exceptionally well on the Obstetrics and Gynecology Core Clerkship rotation receiving Honors. Quinn was great with patients and took the initiative in seeing patients on her own. Her knowledge base exceeded her level and she was able to assimilate her reading and research into her clinical activities. She took charge in a calm and efficient manner. She has excellent potential and will be an excellent house officer. Her performance on the National Board of Clinical Sciences Examination was well above the average of the class. Her fund of knowledge, clinical judgment, history & physical's, presentations, technical skills, patient records, and documentation exceeded the expectations of the department and she successfully completed the Obstetrics & Gynecology program.

Pediatrics: HONORS (Faculty, Small Group Leader) She did well and was an active participant in all of our activities. (Faculty, Nursery) Quinn was a dedicated and very helpful student while in the nursery. She functioned as an intern and rose to the occasion quite well. (Faculty, NICU) Honest, hardworking, and good presentations. (Faculty, Inpatient) Good communication skills, hardworking, good bedside manners, good basic knowledge. (Faculty, Inpatient) Quinn had a strong week in the PICU while I was the attending there. Patient presentations were well delivered and detailed. She was an eager learner. (Senior resident, Inpatient) Quinn was a valuable member of our health-care team. Very caring and knowledgeable of the patients she cared for.

Family Medicine: HONORS Quinn Jackson did a great job during her family medicine rotation. She was well liked by patients, "all of the medical students, she is number one," nurses/office staff, "always nice and easy going," and Dr. Gunda, pediatrician, "wants to learn." Quinn is a conscientious and compassionate person and possesses an excellent fund of knowledge. In my opinion, Quinn's clinical skills in the middle of her third year are commensurate with those of a fourth year student (six months ahead). Quinn is in the top 33% of students I have taught in over 24 years of teaching. Quinn has a talent for seeing patients in an outpatient, office-based setting. She is thinking of being a family doctor, subspecializing in women's health, and this would be a wonderful fit. I plan to stay in touch.

Psychiatry: HONORS Student Doctor Quinn performed very well during her rotation. She performed all assigned duties eagerly and was caring and respectful of patients. Quinn was a very interested student and very competent for her level of education. She was very eager to learn.

Neurology: Quinn Jackson performed very well on the Neurology Clerkship and showed satisfactory basic skills appropriate to the clerkship. Faculty evaluators commented that she was professional, poised, and consistently well-prepared for rounds. She had a pleasant demeanor and interacted well with the entire team. She will be an excellent resident. Quinn did a great job and displayed strong character and clinical skills during her neurology rotation. She was self-motivated and professional always helping out by doing tasks that would forward patient care. She was intellectually curious and had thoughtful questions. Quinn was great to work with; she was always engaged with the team and was able to keep up with the daily clinical changes of patients. She should do well on her other clinical rotations because she is very eager to learn and knows her patients well. Quinn was involved in the clinical decision making and showed appropriate motivation and enthusiasm for learning. She demonstrated an above average

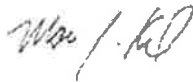
knowledge base that was well applied in addition to an exceptional intellectual curiosity. She always treated others with respect, communicated effectively and was well-liked by patients. She demonstrated an excellent rapport with classmates, residents, and other professional staff. Her patient data, assessments and case presentations were thorough, accurate, well-organized and concise.

SUMMARY


In summary, Quinn Jackson is an academically talented student placing in the top third of her class. Quinn will receive her Masters of Public Health in addition to her M.D. upon graduation this year. Quinn has been an active volunteer in the New Orleans community and has held important leadership positions in our school. I've gotten to know Quinn during her time spent at Tulane. On a personal note, I find her to be patient- centered, compassionate and goal directed.

Based on a review of her entire academic medical school record to date, Ms. Jackson's overall medical school performance has been *excellent* in comparison with her peers at this institution.

Quinn Jackson is a fine physician who will bring great credit to the faculty of the Tulane University Health Sciences Center, to her chosen profession, and to any post-doctoral program in which she elects to train.



Marc J. Kahn, M.D., M.B.A.
Sr. Associate Dean for Admissions and
Student Affairs
Professor of Medicine



L. Lee Hamm, M.D.
Senior Vice President of Tulane University
Dean of the School of Medicine

Louisiana
University
School of Medicine

Whereas

Quinn Michelle Jackson

has duly fulfilled all the requirements prescribed, therefore the degree of

Doctor of Medicine

is this day conferred with all the rights, honors, privileges, and responsibilities pertaining thereto.

In evidence thereof, there is impressed upon this Diploma the seal of the University

and the signatories of the Chair of the Board of Administrators, the President of the University, and the Dean of the School of Medicine.

Given at New Orleans, in the State of Louisiana,

May twentieth, Two thousand and seventeen.

Doris D. Berger
Chair, Board of Administrators



Michael A. Fotts

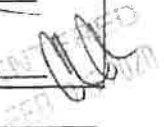
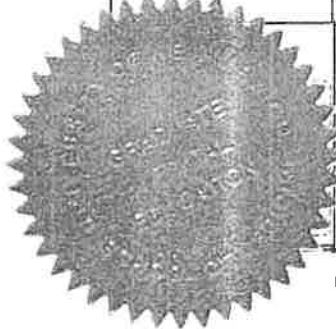
President of the University

R. Lee Hamm

Senior Vice President and Dean, School of Medicine



Verification of Postgraduate Medical Education	
Institution: <u>University of New Mexico School of Medicine Program</u>	Attention: <u>Program Director</u>
Specialty: <u>Family Medicine</u>	Affiliated University: _____
Address: <u>Albuquerque, NM</u>	
Verification For:	Name: <u>Quinn Michelle Jackson</u> Individual's Name on Record (if different from above): _____
Program Participation: Important: Report incomplete postgraduate years (PGY) separate from those that were successfully completed. If the postgraduate year is currently in progress report the expected completion date in the "To" field. Report Internships, Residencies and Fellowships separately. Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.	PGY: <u>1</u> Specialty/Subspecialty: <u>Family Medicine</u> <input checked="" type="checkbox"/> Internship From: <u>6/22/2017</u> To: <u>6/30/2018</u> <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency Successfully Completed?: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Fellowship Accredited by: <input checked="" type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> Research <input type="checkbox"/> RCPC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these
	PGY: <u>2</u> Specialty/Subspecialty: <u>Family Medicine</u> <input type="checkbox"/> Internship From: <u>7/1/2018</u> To: <u>6/30/2019</u> <input checked="" type="checkbox"/> Residency Successfully Completed?: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Chief Residency Accredited by: <input checked="" type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> Fellowship <input type="checkbox"/> RCPC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these <input type="checkbox"/> Research
	PGY: <u>3</u> Specialty/Subspecialty: <u>Family Medicine</u> <input type="checkbox"/> Internship From: <u>7/1/2019</u> To: <u>6/30/2020</u> <input checked="" type="checkbox"/> Residency Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> In Progress <input type="checkbox"/> Chief Residency Accredited by: <input checked="" type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> Fellowship <input type="checkbox"/> RCPC <input type="checkbox"/> APPAP <input type="checkbox"/> None of these <input type="checkbox"/> Research
Unusual Circumstances: Check the correct response. Omitted responses require written explanation. If necessary, you may continue your explanation on a separate sheet of paper.	1. Did this individual ever take a leave of absence or break from his/her training? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 2. Was this individual ever placed on probation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3. Was this individual ever disciplined or placed under investigation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 4. Were any negative reports for behavioral reasons ever filed by instructors? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Please explain any "Yes" response from above:
Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).	
Name: <u>Joe Sparkman</u> Signature: _____ Title: <u>Program Director</u> Date of Signature: <u>10/1/2019</u> Tel: <u>5052726225</u> Fax: <u>5052725184</u> E-Mail: <u>jsparkman@salud.unm.edu</u>	
FID: <u>300778461</u> ACGME ID: <u>1203421197</u> GME CODE: _____	



11 November 2013

Federation of State Medical Boards
Federation Credentials Verification Service
POB 619850
Dallas, TX 75261-5099

Re: Signature Authority for University of New Mexico ACGME Residency Programs

To Whom It May Concern:

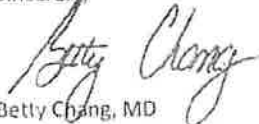
I wish to update the information concerning authorized signature for the University of New Mexico Graduate Medical Education Programs. GME Senior Program Manager Joe Sparkman continues to be the Administrative Director of Graduate Medical Education at the University of New Mexico Health Sciences Center. In this position, he is responsible for verification of medical education training information for the institution. Additionally, this information is published in our GME Policies and Procedures on page 17 of the University of New Mexico Houseofficers and the University Regulations and Benefit Manual.

The Associate Dean for GME, on behalf of the institution, delegates the responsibility for all verification of training dates, as well as other verification of resident data, to the Administrative Director/Senior Program Manager of GME.

Mr. Sparkman has served in this position for a good number of years. I am certain he will be delighted to continue to work with your organization and provide accurate information to the various agencies served by the FCVS.

If I can provide additional information, please feel free to contact my office.

Sincerely,



Betty Chang, MD
Associate Dean for Graduate Medical Education
ACGME Designated Institutional Official



Graduate Medical Education

Medical Professional Name: Jackson, Quinn Michelle

Accreditation ID: 1203421197

Institution: University of New Mexico School of Medicine Program

Specialty: Family Medicine

Unusual Circumstances

Training Period: 7/1/2017 - 6/30/2020 Internship/Residency

Did you have any interruption(s) or extension(s) in your medical education? No

Were you ever placed on probation? No

Were you ever disciplined or placed under investigation? No

Were any negative reports for behavioral reasons ever filed by instructors? No

Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason? No

End of Applicant Reported Unusual Circumstances report for: Jackson, Quinn Michelle

PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board As of Date: 2/4/2020

PRACTITIONER INFORMATION

Name: Jackson, Quinn Michelle
Medical School: Tulane University School of Medicine
New Orleans, Louisiana, UNITED STATES
Year of Grad: 2017
Degree Type: MD

BOARD ACTIONS

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

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
	Individual			07/18/2018

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NEW MEXICO	RS2017-0419	05/22/2017	07/01/2020	01/31/2020
NEW MEXICO	MD2019-1060	12/12/2019	07/01/2022	01/31/2020

US DRUG ENFORCEMENT ADMINISTRATION (DEA)

No DEA found.



New Mexico Medical Board
 2055 S. Pacheco, Building 400
 Santa Fe, NM 87505
 505-476-7220 fax 505-476-7237
 (toll free within New Mexico 800-945-5845)

General Information

Licensee	Quinn M Jackson	License Type	Medical Doctor
Business address	UNM Family and Community Medicine Resident	License Number	MD2019-1060
Business address	MSC 09-5040: 1 University of New Mexico (FPC)	License Status	Active
Business city state zip	Albuquerque NM 871310001	License Date	12/12/2019
Business phone	505-272-8291	**License Expires	07/01/2022
Medical School	Tulane Univ SOM		
Graduation Date	05/20/2017		
*Specialty	Family Medicine		

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

***For PA's only a New Mexico Medical license that has not been renewed by March 1 of the renewal year will remain temporarily active with respect to medical practice until April 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.

* The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: www.abms.org to determine if the physician has earned a specialty certification from this private agency.

ENTERED
 FEB 04 2020

** A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the



New Mexico Medical Board
2055 S. Pacheco, Building 400
Santa Fe, NM 87505
505-476-7220 fax 505-476-7237
(toll free within New Mexico 800-945-5845)

General Information

Licensee Quinn M Jackson License Type Resident
Business address UNM GME License Number RS2017-0419
Business address MSC11 6093 1 UNM License Status Active
Business city state zip Albuquerque NM 871310001 License Date 05/22/2017
Business phone 505-272-6225 **License Expires 07/01/2020
Medical School Tulane Univ SOM
Graduation Date 05/20/2017
*Specialty Family Medicine

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

***For PA's only a New Mexico Medical license that has not been renewed by March 1 of the renewal year will remain temporarily active with respect to medical practice until April 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.

* The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: www.abms.org to determine if the physician has earned a specialty certification from this private agency.

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

PUBLIC ACTIONS:None

ENTERED
FEB 05 2020



ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

Emails with attachments must be sent in PDF format to support@armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

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

Quinn Michelle Jackson, MD

Physician's Full Name (First Middle Last, Suffix, Degree)

Physician's Signature (no rubber stamps)

1-21-2020

Signature Date

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

2020 FEB -3 AM 11:22

RECEIVED
ASMB

ENTERED
FEB 05 2020



ARKANSAS STATE MEDICAL BOARD

& CENTRALIZED CREDENTIALS VERIFICATION SERVICE

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

Emails with attachments must be sent in PDF format to support@armedicalboard.org

AUTHORIZATION AND RELEASE

To Whom It May Concern:


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

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

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

Typed or Printed Name of Physician: Quinn Michelle Jackson

Social Security Number: _____

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

Signature Date: 1-21-2020

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

2020 FEB -3 AM 11:22

ENTERED

FEB 03 2020

RECEIVED

Quinn Jackson MD, MPH
Family Medicine
Albuquerque, NM 87110

EDUCATION

University of New Mexico, Department of Family and Community Medicine, Albuquerque, New Mexico

Resident in Family Medicine, expected graduation June 2020

Tulane University School of Medicine, New Orleans, Louisiana

Doctor of Medicine, 2013-2017

Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana

Masters in Public Health, concentration Global Community Health and Behavior, 2013-2017

University of Florida, Gainesville, Florida

Bachelor of Arts, Women's Studies, 2007-2011

Cum Laude

EMPLOYMENT HISTORY

Planned Parenthood of North Florida, Gainesville, Florida

Family Planning Assistant, 2008-2013

Responsible for delivering pregnancy options and contraception counseling, taking patient histories and answering patient questions for reproductive age women and men

Bread and Roses Women's Health Center, Gainesville, Florida

Medical Assistant, 2010-2011

Responsible for delivering pre-abortion counseling, assisting and monitoring patient during procedure and managing recovery area

LEADERSHIP

UNM Family Medicine Residency

Chief Resident, June 2019- June 2020

UNM Family Medicine Residency Quality Improvement Committee

Member, August 2017-current

Coordinate with faculty to implement quality improvement initiatives devised at monthly residency wide quality improvement forums

Medical Students for Choice- Tulane Chapter

President, October 2013-January 2015

Coordinated events and lectures relating to family planning and abortion for medical students, organized manual vacuum aspiration and IUD insertion skills workshops and directed a production of the Vagina Monologues

NON-PROFIT LEADERSHIP

Medical Students for Choice Board of Directors

Member of Board of Directors, April 2015-April 2017

Secretary April 2016-April 2017

2020 FEB -3 AM 11:22

RECEIVED
ASMD

ENTERED
FEB 05 2020

TEACHING EXPERIENCE

UNM Family Medicine Chief Resident, Maternal Child Health Section

Led manual vacuum aspiration workshop with faculty. Delivered lectures for resident didactics on common OB triage complaints, outpatient management of liver disease and caring for transmasculine patients.

Tulane Sexual Health Elective, New Orleans, Louisiana

Student leader, August-December 2014

Organized a ten-week lecture series on selected topics in sexual health for medical students.

Adapted and delivered lectures on "Transgender Health and the Transition Process" and "Sex and Disability."

PROFESSIONAL ASSOCIATIONS

Society of Family Planning, 2014- present

American Academy of Family Physicians, 2015- present

National Abortion Federation, 2017- present

REFERENCES

Dave Stromberg- faculty mentor at UNM

Gabrielle Goodrick- independent provider in Phoenix, AZ. Can attest to competency up to 13.6 wga.

Kira Paisley- faculty mentor at UNM. Can attest to competency up to 13.6 wga.

Nicole Yonke- faculty mentor at UNM. Can attest to competency up to 13.6 wga.

2020 FEB - 3 AM 11:23

RECEIVED
ASMP

ENTERED
FEB 05 2020