Application Summary

License Type:	**Physician's and Surgeon's**
Application:	**Physician's and Surgeon's - Initial Application**
Application Number:	**14839551**
Application Date:	**12/06/2020 (mm/dd/yyyy)**

Application Questions

Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?	**No**
Are you applying with an Individual Taxpayer Identification Number (ITIN)?	[redacted]
Have you served or are you currently serving in the military?	
Are you requesting expediting of this application for spouses or domestic partners of an active duty member of the U.S. Armed Forces?	
Are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces?	
Are you requesting expediting of this application to practice in a medically underserved area or population?	

Personal Detail

First Name:	**Quinn**
Last Name:	**Jackson**
Birthdate:	****/**/******
Gender:	**Female**
SSN/ITIN:	*************

Addresses

License Related Addresses

Address of Record

Warning:	**In order to protect your privacy and identity, address will not be displayed.**

General Information

Are you a registered sex offender?	[redacted]

Previous Application or License

Have you served or are you currently serving in the U.S. Military?	[redacted]
Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the U.S. Armed Forces?	
Have you ever filed an application for a Physician's and Surgeon's License or other license in California that has been withdrawn, abandoned, or denied?	
Have you previously held a Physician and Surgeon License in California?	**No**

Examinations

Are you certified by the Educational Commission for Foreign Medical Graduates?	**No**

Examinations 1

Examination:	**United States Medical Licensing Examination (USMLE) Step 1**
Date Passed:	**04/16/2015 (mm/dd/yyyy)**

Examinations 2

Examination:	**United States Medical Licensing Examination (USMLE) Step 2CK**
Date Passed:	**05/26/2016 (mm/dd/yyyy)**

Examinations 3

Examination:	**United States Medical Licensing Examination (USMLE) Step 2CS**
Date Passed:	**05/12/2016 (mm/dd/yyyy)**

Examinations 4

Examination:	**United States Medical Licensing Examination (USMLE) Step 3**
Date Passed:	**06/15/2018 (mm/dd/yyyy)**

Medical Education

Medical School Name:	**Tulane University School of Medicine**
Mailing Address of the Medical School:	**1430 Tulane Ave New Orleans, LA 70112**
Attendance Start Date:	**08/01/2013 (mm/dd/yyyy)**
Attendance End Date:	**05/20/2017 (mm/dd/yyyy)**
Were You Awarded a Degree?	**Yes**
Title of Degree Awarded:	**MD - Doctor of Medicine**

Issue Date of Degree: **05/20/2017 (mm/dd/yyyy)**

ACGME or RCPSC Accredited Postgraduate Training Programs

Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada? **Yes**

ACGME or RCPSC Accredited Postgraduate Training Programs

Program Facility Name: **University of New Mexico Family and Community Medicine**

City: **Albuquerque**

State/Province: **New Mexico**

Specialty: **Family Medicine**

Training Start Date: **07/01/2017 (mm/dd/yyyy)**

Training End Date: **06/30/2020 (mm/dd/yyyy)**

ACGME or RCPSC Accredited Postgraduate Training Programs

Have you ever received partial or no credit for a postgraduate training program? [redacted]

Have you ever taken a leave of absence or break from your training?

Have you ever been terminated, dismissed or expelled from a program?

Have you ever been placed on probation for any reason?

Have you ever been disciplined or placed under investigation?

Have you ever had any limitations or special requirements placed upon you for clinical performance professionalism, medical knowledge, discipline, or for any other reason?

Have you ever had a postgraduate training program contract not be renewed or offered for a following year?

Medical License Information

Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province? **Yes**

Medical License(s) 1

U.S. State, U.S. Territory or Canadian Province: **New Mexico**

License Number: **MD2019-1060**

Practice Start Date: **12/12/2019 (mm/dd/yyyy)**

Practice End Date:	**06/30/2020 (mm/dd/yyyy)**

Medical License(s) 2

U.S. State, U.S. Territory or Canadian Province:	**Oklahoma**
License Number:	**35521**
Practice Start Date:	**07/27/2020 (mm/dd/yyyy)**

Medical License(s) 3

U.S. State, U.S. Territory or Canadian Province:	**Arkansas**
License Number:	**E-12988**
Practice Start Date:	**07/27/2020 (mm/dd/yyyy)**

Medical License(s) 4

U.S. State, U.S. Territory or Canadian Province:	**Kansas**
License Number:	**04-43246**
Practice Start Date:	**07/27/2020 (mm/dd/yyyy)**

Medical License(s) 5

U.S. State, U.S. Territory or Canadian Province:	**Missouri**
License Number:	**2020015507**
Practice Start Date:	**07/27/2020 (mm/dd/yyyy)**

ABMS Certification

Are you currently certified by a Member Board of the American board of Medical Specialties?	**Yes**

Malpractice History

Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgement, or arbitration?	[redacted]

Disciplinary History

Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	[redacted]
Have you ever been denied a license to practice medicine or is any denial pending against you?	
Have you ever had any license to practice medicine subjected to any disciplinary action or is any disciplinary action pending against any of your licenses to practice medicine?	

Have you ever surrendered a license to practice medicine or have you ever had any license to practice medicine revoked, suspended, or placed on probation?

Have you ever had any license to practice medicine subjected to any action including, but not limited to, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?

Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?

Have you ever resigned from a medical staff in lieu of disciplinary or administrative action or is any disciplinary action pending against your hospital or staff privileges?

Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?

Have you ever had any healing arts license or certificate disciplined by another state or federal territory?

Practice Impairment or Limitations

Are you currently enrolled in, or participating in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?

Do you currently have any condition (including, but not limited to emotional, mental, neurological or other physical, addictive, or behavioral disorder) that impairs your ability to practice medicine safely?

Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?

Family Physician Training Program Voluntary Fee

Would you like to contribute?

Amount:

Attachments

Fees

Application Fee	**$442.00**
Department of Justice (DOJ) Fee	**$32.00**

Federal Bureau of Investigation (FBI) Fee	**$17.00**
Initial License Fee	**$783.00**
StephenM.ThompsonLRP	**$25.00**
Family Physician Training Program Voluntary Fee	**$25.00**
Total Amount Due:	**$1324.00**

Applications are not considered submitted for processing until payment is received.

Attestation

I attest I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same 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 and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.
I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto is a sufficient basis for denying or revoking a license.

Signature: Date:

RC #2053851

MD USE ONLY

PHOTOGRAPH AND NOTICE

[redacted]

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act.

Reviewed LIZ-11

Staff Initials RC

Photo

DECLARATION

Full Legal Name (First, Middle, Last, Suffix) | Date of Birth (mm/dd/yyyy)

Applicant Name & DOB

The applicant, Quinn Jackson [redacted], being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; and that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same 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 and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION, OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date

SIGN LEGAL NAME: [signature] **DATE:** 12/11/2020

NOTARY SECTION

Applicant Signature

SIGNATURE OF APPLICANT: [signature]
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Missouri County of Jackson

(NOTARY SEAL)

Applicant Name & Notary Date

Subscribed and sworn to (or affirmed) before me on this

11th day of December, 20 20,

Print Applicant's Legal Name

by, Quinn Jackson

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

MEGAN BORGARDTS
Notary Public - Notary Seal
Platte County - State of Missouri
Commission Number 13515919
My Commission Expires Mar 29, 2022

Notary Signature & Seal

[signature]
SIGNATURE OF NOTARY PUBLIC

Form L1F

PHOTOGRAPH AND NOTICE

MBC USE ONLY

[redacted]

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act.

Reviewed LIA-LIE ✓

Staff Initials & Date RC 2/3/2

Photo ✓

DECLARATION

Full Legal Name (First, Middle, Last, Suffix) | Date of Birth (mm/dd/yyyy)

Applicant Name & DOB ✓

The applicant, QUINN MICHELLE JACKSON, [redacted], being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; and that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same 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 and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION, OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date ✓

SIGN LEGAL NAME: [signature] **DATE:** 01/28/2021

NOTARY SECTION

Applicant Signature ✓

SIGNATURE OF APPLICANT: [signature]

(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of MISSOURI County of CLAY

Subscribed and sworn to (or affirmed) before me on this

28 day of JANUARY, 20 21,

Print Applicant's Legal Name

by, QUINN MICHELLE JACKSON

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Applicant Name & Notary Date ✓

(NOTARY SEAL)

NOTARY PUBLIC NOTARY SEAL STATE OF MISSOURI

CHRISTINA BLAKE MEIER
My Commission Expires
February 26, 2022
Clay County
Commission #18716915

Notary Signature & Seal ✓

[signature]

SIGNATURE OF NOTARY PUBLIC

Form L1F

Medical Board of California

Timeline of Activities

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487

APPLICANT INFORMATION

Legal Name

Full Last Name	First Name	Middle Name	Suffix
JACKSON	QUINN	MICHELLE	

Date of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation
[redacted]	[redacted]	Tulane University

TIMELINE OF ACTIVITIES

A complete timeline of activities from graduation of medical school to present is required. Provide a written chronological description of all your professional and non-professional activities. Include a detailed description of your duties and responsibilities for any externship, observership, or volunteer activity in California. Dates shall be reported in chronological order in month/year (mm/yyyy) format.

Location (Facility Name, Address, and Supervisor): University of New Mexico Dept of Family Medicine MSC 09-5040 1 Univ of New Mexico Albuquerque NM 87131 Daniel Waldman, MD
Start Date: 07/01/2017
Activities: Resident Physician
End Date: 06/30/2020

Location (Facility Name, Address, and Supervisor): Planned Parenthood Great Plains 4401 W 109th St #100 Overland Park, KS 66211 Orin Moore, MD
Start Date: 07/27/2020
Activities: Family planning and abortion services
End Date: present

Location (Facility Name, Address, and Supervisor)
Start Date

Activities
End Date

Location (Facility Name, Address, and Supervisor)
Start Date

Activities
End Date

SIGN LEGAL NAME: [signature] **DATE:** 12/6/2020

Applicant's signature and date are required

Form TOA

New Mexico Medical Board
2055 S. Pacheco Street, Bldg. 400
Santa Fe, New Mexico 87505
505-476-7220

LICENSE VERIFICATION

Licensee Name: Quinn M Jackson, MD
Licensee Address: [redacted]

Date of Birth: [redacted]

School Name
Tulane Univ SOM

Graduation Date
05/20/2017

Specialties:
Family Medicine

Licensed By:

License #	Issue Date	Expiration Date	Status	License Type
MD2019-1060	12/12/2019	07/01/2022	Active	Medical Doctor

Our records indicate there is No Derogatory Information and the license is in good standing.

This license information was last updated on: 11/16/2020

Antoinette Griego

Antoinette Griego, Licensing Manager

Date: December 06, 2020

Board of Medical Licensure & Supervision
State of Oklahoma

101 N.E. 51st Street
Oklahoma City, OK 73105

P.O. Box 18256
Oklahoma City, OK 73154-0256

Letter of Verification

December 06, 2020

This is to certify that the records of this Board indicate on the date of this letter the following information regarding:

Name:	QUINN MICHELLE JACKSON
Address Date:	August 21, 2020
Address 1:	
Address 2:	
Address 3:	
City, State, ZIP:	

Profession:	MEDICAL DOCTOR
Profession Type:	MD
License Number:	35521
License Date:	02/25/2020
Status:	Active
Status Class:	
Expiration Date:	02/01/2021
Endorsed By:	USMLE
Restricted To:	

Disciplinary Actions:

Date	Description
No Disciplinary Actions Taken	

Previous Licenses:

Type	Issued	Expired

Details of Disciplinary Action, if applicable, will be made available by photocopy from the public file upon written request only.

To expedite the verification of licensure/certification process, the above is the standard format for all professions regulated by this board

The Oklahoma State Board of Medical Licensure and Supervision certifies that the verification data displayed here is accurate according to the information stored in our database as of 12/06/2020.

Lisa Cullen
Director of Licensing
(405) 962-1400 ext 153

ARKANSAS STATE MEDICAL BOARD

1401 West Capitol, Suite 340, Little Rock, Arkansas 72201 • (501) 296-1802 • FAX (501) 603-3555
www.armedicalboard.org

RC
#2053851
12/6

December 8, 2020

Quinn Michelle Jackson, M.D.

CERTIFICATION

I, Amy E. Embry, Executive Director of the Arkansas State Medical Board, do hereby certify that the enclosed certification of the above referenced practitioner is true and correct as same appears on file in this office.

Witness my hand and official seal of the Board, this 8th day of December 2020.

ARKANSAS STATE MEDICAL BOARD

BY: Amy E. Embry
Amy E. Embry
Executive Director

ARKANSAS STATE MEDICAL BOARD

1401 West Capitol, Suite 340, Little Rock, Arkansas 72201 (501) 296-1802 FAX: (501) 603-3555

www.armedicalboard.org

Detailed License Verification

Queried on: Tuesday, December 08, 2020 at: 8:47 AM

General Information

Name: Quinn Michelle Jackson, M.D.

Specialty: Family Medicine

Address Information

Mailing Address: [redacted]

Address 2:

City/State/Zip:

Phone:

Fax:

License Information

License Number: E-12988

Original Issue Date: 3/6/2020

Expiration Date: 3/31/2021

License Status: Active

License Category: Unlimited

No Information Found for: License Board History

Kansas State Board of Healing Arts
800 SW Jackson, Suite A-Lower Level
Topeka, KS 66612

Kansas
State Board of Healing Arts

Phone: 785-296-7413
Fax: 785-368-7103
KSBHA_healingarts@ks.gov
www.ksbha.org

Tucker Poling, Interim Executive Director

Laura Kelly, Governor

December 06, 2020

California, Medical Board of
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

This is to certify that: Quinn Jackson has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number:	04-43246
Year of Birth:	[redacted]
Profession:	MD Active License
License Status:	Current
Original License Date:	05/08/2020
Expiration Date:	07/31/2021
Disciplinary Action:	No

STATE BOARD OF HEALING ARTS
KANSAS

Please visit www.KSBHA.org to view Board Actions available to the public. To receive certified copies of Board Actions, please email KSBHA_openrecords@ks.gov. All communications to the Board must include the name and license number of the licensee.

Michael L. Parson
Governor
State of Missouri

Sarah Ledgerwood, Interim Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Missouri Department of
Commerce & Insurance
Chlora Lindley-Myers, Director

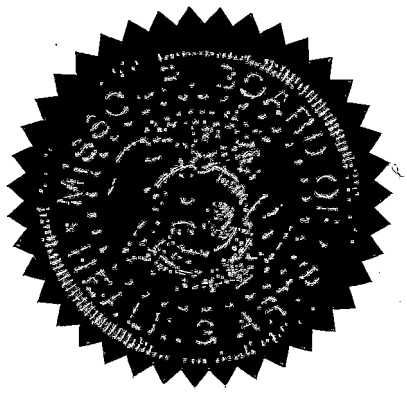
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
573-751-3166 FAX
800-735-2966 TTY Relay Missouri
800-735-2466 Voice Relay Missouri

Connie Clarkston
Executive Director
healingarts@pr.mo.gov
pr.mo.gov/healingarts

To:
California Medical Board
2005 Evergreen St. Suite 1200
Sacramento, CA 95815

This is to certify that the records of the Missouri Board of Healing Arts indicate the following information regarding Quinn Michelle Jackson, M.D..

LICENSE TYPE:	Medical Physician & Surgeon
LICENSE NUMBER:	2020015507
DATE ISSUED:	6/7/2020
STATUS:	Active
EXPIRATION DATE:	1/31/2022
DISCIPLINARY ACTION:	None



Kyle Maddox
Verifications Clerk

12/08/2020
Date

This is the only form that will be used by the Missouri State Board of Registration for the Healing Arts for the purpose of license verification.