DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

MEDICINE AND OSTEOPATHY (MD/DO)
NEW LICENSE APPLICATION

All applicants must complete every section of this application and submit the original application and all require[...] more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleadi[...] for disciplinary action and could be cause for criminal prosecution pursuant to *DC Code 22-2405*. YOU MUST INI[...] APPLICATION.

If you have any questions, call HRLA Customer Service at **(877) 672-2174, Monday through Friday, 8:30AM to 4:[...]PM EST.**

SECTION 1: LICENSURE TYPE & FEES

Professional Designation:	Graduate Type:	Application Type:
☑ Medicine & Surgery (MD)	☑ U.S./Canada	☐ License by Examination ($805.00)
☐ Osteopathy & Surgery (DO)	☐ International	

SECTION 2: APPLICANT INFORMATION

First Name: Donna	MI: L	Last Name: Burkett
Date of Birth: [redacted]		SSN: [redacted]

Gender: ☐ Male ☑ Female

Degree(s) Held: ☑ MD ☐ DO ☐ MBBS ☐ MBA ☐ MPH ☐ PHD ☐ Other:

Race & Ethnicity (Optional):
- ☐ American Indian/Alaskan Native
- ☐ Asian/South Asian
- ☐ Black/African American
- ☑ Caucasian/White
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Hispanic or Latino
- ☐ Choose Not to Disclose
- ☐ Other: ____________

Language(s) Spoken (Other than English):
- ☐ Spanish ☐ Vietnamese ☑ French
- ☐ Tagalog ☐ Amharic ☐ Mandarin
- ☐ Cantonese ☐ Russian ☐ German
- ☐ Korean ☐ Other: ____________

SECTION 3: OTHER NAME(S) USED

If your name has changed at any point since you have taken any exams or attended college or university, you must provide a copy of a legal name change document for each time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders, copies of social security cards or a passport.

First Name:	MI:	Last Name:
First Name:	MI:	Last Name:
First Name:	MI:	Last Name:

SECTION 4: MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☑ HOME ADDRESS ☐ BUSINESS ADDRESS

SECTION 5: HOME ADDRESS

A P.O. Box may NOT be used for an address. Home address information will NOT be made available to the public.

Current Home Address: [redacted]

City: Washington	**State:** DC	**Zip Code:** 20016
Phone Number: [redacted]	**Email Address:** [redacted]	

SECTION 6: BUSINESS ADDRESS(ES)

A P.O. Box may NOT be used for an address. Business address information WILL be made available to the public.

Current Business Address #1: 784 ~~Colchester Ave~~ Hercules Dr. Ste ~~[illegible]~~ 110

City: Colchester	**State:** VT	**Zip Code:** 05446
Phone Number: (802) 448-9717	**Email Address:** donna.burkett@ppnne.org	

Current Business Address #2:

City:	**State:**	**Zip Code:**
Phone Number:	**Email Address:**	

IMPORTANT MESSAGE RE: UPDATING CONTACT INFORMATION

Physicians are required to update changes to their name, home address or business address within thirty (30) days of the change. Failure to do so may result in disciplinary action. It is imperative that you update your information in writing, either via mail or email, to the point of contact listed below:

Attn.: District of Columbia Board of Medicine
899 N. Capitol St. NE, 2nd Floor
Washington, DC 20002
E: dcbomed@dc.gov

SECTION 7: MEDICAL SCHOOL(S) ATTENDED

List all medical schools attended, in reverse chronological order, beginning with the most recent at the top. Transcripts should be provided in a sealed envelope from the issuing institution for each school that you attended and listed below. Use additional sheets if necessary.

School #1 Name: UNC-Chapel Hill	**Graduation Date:** May 1995	**Degree/Certificate Awarded:** MD
City: Chapel Hill	**State:** NC	**Country (if not the United States):**
School #2 Name:	**Graduation Date:**	**Degree/Certificate Awarded:**
City:	**State:**	**Country (If not the United States):**

SECTION 8: POST-GRADUATE MEDICAL TRAINING

List all post-graduate medical training you attended, regardless of whether you completed the program. Include both accredited and non-accredited internships, residencies and fellowships. Also include verification letters from your training programs. For "Type of Position", use the letter key code below. List experience in reverse chronological order, beginning with the most recent. Explain all gaps greater than three (3) months. Use additional sheets if necessary.

Position Key Code:

A. Fellowship | **B.** Internship | **C.** Residency | **D.** Other

Program #1 Name: OHSU Family Medicine	Start Date: 6/1995	End Date: 6/1998	Type of Position: Resident
City: Portland	State: OR		Country (if not the United States):
Program #2 Name:	Start Date:	End Date:	Type of Position:
City:	State:		Country (if not the United States):
Program #3 Name:	Start Date:	End Date:	Type of Position:
City:	State:		Country (if not the United States):
Program #4 Name:	Start Date:	End Date:	Type of Position:
City:	State:		Country (if not the United States):
Program #5 Name:	Start Date:	End Date:	Type of Position:
City:	State:		Country (if not the United States):
Program #6 Name:	Start Date:	End Date:	Type of Position:
City:	State:		Country (if not the United States):

SECTION 9: WORK EXPERIENCE

List **ALL** work experience covering the five (5) year period prior to the submission of the application. Explain all gaps greater than three (3) months. Use additional sheets if necessary.

Employer #1 Name:	Start Date:	End Date:	Reason for Leaving:
Planned Parenthood of Northern New England	9/2013	current	moving to DC area
City: Colchester	State: VT		Country (if not the United States):
Employer #2 Name:	Start Date:	End Date:	Reason for Leaving:
City:	State:		Country (if not the United States):
Employer #3 Name:	Start Date:	End Date:	Reason for Leaving:
City:	State:		Country (if not the United States):
Employer #4 Name:	Start Date:	End Date:	Reason for Leaving:
City:	State:		Country (if not the United States):

SECTION 10: OTHER MEDICAL LICENSES

List all states and jurisdictions in which you have **EVER** held a medical license, regardless of status. Verifications should be provided from the issuing jurisdiction(s) for each license. For license type, indicate whether it was a full license, a temporary license, a training license, or any other type of license issued to you. Use additional sheets if necessary.

Jurisdiction	License Type:	Issue Date:	Exp. Date:	License Number:
Jurisdiction #1: Vermont	MD - full	8/7/2013	11/30/2022	042.0012729
Jurisdiction #2: New Hampshire	FULL MD unrestricted permanent	8/7/13	6/30/2021	16261
Jurisdiction #3: Maine	FULL MD - permanent	9/16/2013	1/31/2022	MD19833
Jurisdiction #4: North Carolina	FULL MD	2/22/2001	1/10/2014	200100124

(cont)

DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

SECTION 9: WORK EXPERIENCE

List **ALL** work experience covering the five (5) year period prior to the submission of the application. Explain all gaps greater than three (3) months. Use additional sheets if necessary.

Employer #1 Name:	Start Date:	End Date:	Reason for Leaving:
City:	State:		Country (if not the United States):
Employer #2 Name:	Start Date:	End Date:	Reason for Leaving:
City:	State:		Country (if not the United States):
Employer #3 Name:	Start Date:	End Date:	Reason for Leaving:
City:	State:		Country (if not the United States):
Employer #4 Name:	Start Date:	End Date:	Reason for Leaving:
City:	State:		Country (if not the United States):

SECTION 10: OTHER MEDICAL LICENSES (cont)

List all states and jurisdictions in which you have **EVER** held a medical license, regardless of status. Verifications should be provided from the issuing jurisdiction(s) for each license. For license type, indicate whether it was a full license, a temporary license, a training license, or any other type of license issued to you. Use additional sheets if necessary.

Jurisdiction	License Type	Issue Date	Exp. Date	License Number
Jurisdiction #1: South Carolina	License Type: FULL Medical Physician	Issue Date: 9/21/2007	Exp. Date: 6/30/2015	License Number: MD 29999
Jurisdiction #2: Virginia	License Type: FULL Medical	Issue Date: 2/23/2007	Exp. Date: 1/31/2014	License Number: 0101241288
Jurisdiction #3: West Virginia	License Type: FULL Medical	Issue Date: 5/14/2007	Exp. Date: 6/30/2014	License Number: 22710
Jurisdiction #4: Oregon	License Type: FULL ~~10/18~~ Medical	Issue Date: 10/18/1996	Exp. Date: 12/31/2001	License Number: MD 20096

SECTION 11: PRACTICE SPECIALTIES & BOARD CERTIFICATIONS

If you practice in a specialty area, indicate your specialty in the boxes below. Use the specialty codes listed if applicable. If a specialty code is not listed, please write the full specialty in the boxes provided.

AC Academic Medicine
ADM Administrative Medicine
AI Allergy & Immunology
AN Anesthesiology
DE Dermatology
EM Emergency Medicine
FM Family Medicine
GE Geriatrics
HOS Hospitalist
IN Internal Medicine (General)
IN Internal Medicine
- IN/CA Cardiology
- IN/EN Endocrinology
- IN/GI Gastroenterology
- IN/HEM Hematology
- IN/ID Infectious Disease
- IN/NEP Nephrology
- IN/NEU Neurology
- IN/ONC Oncology
- IN/PCC Pulmon. Critical Care
- IN/PUD Pulmon. Disease
- IN/RH Rheumatology

MG Medicine Genetics
NU Nuclear Medicine
OB Obstetrics & Gynecology
OC Occupational Health
OP Ophthalmology
OMT Osteopathic Manipulative Treatment
ENT Otolaryngology
PA Pathology
PED Pediatrics (General)
PED Pediatrics
- PED/AD Adolescent Medicine
- PED/CA Cardiology
- PED/EN Endocrinology
- PED/GI Gastroenterology
- PED/HEM Hematology
- PED/NEO Neonatology
- PED/NEP Nephrology
- PED/NEU Neurology
- PED/ONC Oncology
- PED/PCC Pulmon. Critical Care
- PED/PUD Pulmon. Disease
- PED/RH Rheumatology

PMR Physical Medicine & Rehabilitation
PR Preventive Medicine/Public Health
PSY Psychiatry
RA Radiology
REM Research Medicine
SU Surgery (General)
SU Surgery
- SU/BT Burn/Trauma
- SU/CS Cardiac Surgery
- SU/CO Colon & Rectal Surgery
- SU/GE General Surgery
- SU/NE Neurological Surgery
- SU/OR Orthopedic Surgery
- SU/PL Plastic Surgery
- SU/TH Thoracic Surgery
- SU/TP Transplant
- SU/UR Urology
- SU/VA Vascular

Specialty #1: FM
Specialty #2:
Specialty #3:
Specialty #4:

If you are Board Certified in a specialty, please list the specialty and the related certifying agency below.

Certifying Board #1: ABFM	Certifying Agency:
Certifying Board #2:	Certifying Agency:
Certifying Board #3:	Certifying Agency:
Certifying Board #4:	Certifying Agency:

SECTION 12: REQUIRED SCREENING QUESTIONS

Please answer questions 1 through 15 by placing an "X" in the appropriate boxes. If you answer "Yes" to any question, you must provide full information and complete details on a separate sheet of paper, as well as attach copies of all relevant documents such as final court orders. Failure to provide relevant information will delay the application processing time.

#	Question	Answer
1.	Have you ever been arrested, charged, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor, including driving under the influence or while impaired, but excluding minor traffic violations?	☐ Yes ☒ No
2.	Have you been a defendant or respondent to a claim for damages or a malpractice action? If you answer "Yes", please complete the Malpractice Claims Form and submit it along with all relevant court documents (e.g., Complaint, Answer, and Final Order/Decision). A separate Malpractice Claims Form MUST be completed for each malpractice case.	☐ Yes ☒ No
3.	Have you ever voluntarily surrendered a license or registration certificate, or allowed it to lapse, after formal charges had been brought against you or while you were under investigation?	☐ Yes ☒ No
4.	Have you ever surrendered your clinical privileges, voluntarily or involuntarily, or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	☐ Yes ☒ No
5.	Have you ever been terminated or resigned, voluntarily or involuntarily, from a clinical or professional training program for any reason?	☐ Yes ☒ No
6.	Has any licensing authority, in any healthcare field, taken adverse action against your license or privileges or informed you of any pending charges?	☐ Yes ☒ No
7.	Has any licensing authority, health facility, or peer review board, in any healthcare field, informed you of any pending charge(s) or investigation(s) against you?	☐ Yes ☒ No
8.	Are you presently now, or have you ever been, under a corrective action plan imposed by an employer, medical facility or educational program?	☐ Yes ☒ No
9.	Do you have a medical condition or have you become aware of any medical condition that impairs or limits your ability to practice your profession?	☐ Yes ☒ No
10.	Have you ever engaged in any conduct that either indicated an impairment, or actually impaired, your ability to practice your profession?	☐ Yes ☒ No
11.	Have you ever entered into a monitoring program for purposes of monitoring your abuse of alcohol, drugs, or other controlled substances?	☐ Yes ☒ No
12.	Have you ever entered into a monitoring program for purposes of monitoring your professional behavior including recordkeeping, billing, boundaries, quality of care or any other matter related to the practice of your profession?	☐ Yes ☒ No
13.	Within the last ten (10) years have you voluntarily resigned, been asked to resign, terminated, or disciplined by any employer?	☐ Yes ☒ No
14.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	☐ Yes ☒ No
15.	Have you ever been excluded from any federal or state run insurance program, including Medicare and/or Medicaid?	☐ Yes ☒ No

SECTION 13: CLEAN HANDS

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Requirement

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed to revoke your license or permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do any of the below statements apply to you:

- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 31, Chapter 24 (The Compulsory/No-Fault Motor Vehicle Insurance Act of 1982);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 3 (Department of For-Hire Vehicles Establishment Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 15 (Registration of Motor Vehicles);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication Act of 1978);
- I owe more than $100 in fines, penalties, or interest assessed by another jurisdiction; provided, that a reciprocity agreement is in effect between the jurisdiction and the District;
- I owe more than $100 in past due taxes;
- I owe more than $100 in any outstanding fines, penalties, or interest due to the District of Columbia;
- I owe any amount of past due District of Columbia Water and Sewer Authority service fees;
- I owe any amount of a vehicle conveyance fee pursuant to D.C. Official Code Title 50, Chapter 23;
- I owe any amount of past due fines, penalties, or past due restitution on behalf of an employee due to a violation of D.C. Official Code Title 32, Chapters 1A, 10, 13 or Title 2, Subchapter X-A; or
- I have failed to file required District tax returns.

☐ Yes ☑ No

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861, et seq.).

Vermont

USA

DRIVER'S LICENSE

4d LICENSE NO.

3 DOB

4a ISS 02/24/2017

4b EXP

1 BURKETT

2 DONNA LYNN

8

15 Sex F

16 Hgt 5'-09"

17 Wgt 160 lb

18 Eyes BRO

9 Class D

9a End NONE

12 Restrictions B

5 DD

Rev 02/20/2013

DONOR

Vermont Board of Medical Practice

Lookup Detail View

Name and Address

Name	Public Address	Actions
Donna Lynn Burkett	[redacted]	None

Registration Information

License Type	License	Status	First Date Licensed	Issue Date	Expiration Date
Physician	042.0012729	ACTIVE	08/07/2013	10/05/2020	11/30/2022

Specialties

Specialty
Family Practice

Supervisees

Supervisee	License	License Type	Relationship Type	Practice Location
Adrienne Jean Voutila	055.0031233	Physician Assistant	Primary Supervising Professional	PPNNE
Amy S. Borgman	055.0030098	Physician Assistant	Primary Supervising Professional	PPNNE
Anne Sarver Hildreth	055.0030584	Physician Assistant	Primary Supervising Professional	PPNNE

Generated on: 10/9/2020 6:17:37 PM

NEW HAMPSHIRE Online Licensing

Person Information

Name: DONNA L BURKETT, MD

Address Information

Address: PLANNED PARENTHOOD NORTHERN NEW ENGLAND 784 HERCULES DR - STE 110 **City:** COLCHESTER **Zip:** 05446 **State:** VT

Phone: 8024489700

License Information

License No: 16261 **Profession:** Medicine **License Type:** Physician

License Status: Current **Issue Date:** 8/7/2013 **Expiration Date:** 6/30/2021

Additional Information

Specialty: Family Practice/Family Medicine

Board Certification Information

Board Certified	Certification	Expiration	ABMS Board Specialties
Yes	FP		
Yes	Spring 2015	Dec 31 2025 12:00AM	Family Medicine

Medical Education Information

Type	Facility Name	Country	Year
Medical School	UNIVERSITY OF NC @ CHAPEL HILL	USA	1995
Internship	OREGON HEALTH SCIENCES UNIVERSITY - PORTLAND, OR		1996
Residency	OREGON HEALTH SCIENCES UNIVERSITY - PORTLAND, OR		1998

Remarks

No Related Documents

Disclaimer: The JCAHO and the NCQA consider on-line status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards.

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BOARD OF LICENSURE IN MEDICINE

DONNA LYNN BURKETT, MD

MEDICAL DOCTOR

License Number: MD19833
Status: Active
First Licensure: 09/16/2013
Expiration Date: 01/31/2022

History

Detailed license history prior to November 14, 2011 is unavailable online.

License Type	Start Date	End Date
MEDICAL DOCTOR	09/16/2013	01/31/2022

Specialty (1 record) hide

The Board does not verify current specialties. To determine if a physician has been board certified by the American Board of Medical Specialties please visit www.abms.org.

Description	Origin
Family Practice	ABMS Board Member certified

Disciplinary or Adverse Licensing Actions

The Board does not list adverse licensing actions taken by other jurisdictions. To determine if a licensee may have had an adverse licensing action in another jurisdiction please visit www.docinfo.org.

None.

GENERAL INFORMATION

Gender: Female
NPI Number: 1760445506

Other Addresses (1 record) hide

Address	Type
784 HERCULES DR STE 110 COLCHESTER, VT 05446-8049	Business

Other Phone Numbers (1 record) hide

Phone Number	Type
+1 (800) 230-7526	Work

Licensee Information

Information as of 10/09/2020

Last Updated by Licensee on 08/29/2013

Donna Lynn Burkett - MD

LICENSE#: *200100124*
ISSUE DATE: *02/12/2001*

LICENSE STATUS: *Inactive*
EXPIRE DATE: *02/03/2014*

Public Action: No

Licensee General Information

Active Supervisee

Supervisee	Type	Status	Approval Date
Stone, Morgan	NP	Active	09/22/2006

North Carolina Hospital Admitting Privileges

Out of State Active/Inactive Licenses

New Hampshire

Oregon

South Carolina

Vermont

Virginia

West Virginia

Out of Country Active/Inactive Licenses

None Reported

Print this page **Board: Medical Board**

South Carolina Board of Medical Examiners
Website Verification

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND
128 LAKESIDE AVE, STE 301
BURLINGTON, VT 05401

Name: Donna L Burkett **Profession:** MD **Office Phone:** 8024489782

Basis: US 1996 **School:** NC **Graduation:** 05/14/1995

License No: 29999 **Date Issued:** 09/21/2007 **Expiration:** 06/30/2015

Specialty: FP*

Rx#: **Rx Issue Date:**

Primary Source Verification of Graduation Certified

Hospital Affiliation (s): None

Credential Status: Inactive
No disciplinary action taken by the Board.

Board Public Action History:

View Orders View Other License for this Person

No Orders Found

License History:
Temporary License Issue Date: 06/15/2007

Verification disclaimer

Virginia Department of Health Professions
License Lookup

Current as of 10/09/2020 18:24

License Information

License Number	0101241288
Occupation	Medicine
Name	Donna L Burkett
Address	Asheville, NC 28801
Initial License Date	02/23/2007
Expire Date	01/31/2014
License Status	Expired
Additional Public Information*	No

Back to License Lookup Result

This serves as primary source verification of the credential issued by the Commonwealth of Virginia and meets the requirements of the Joint Commission.

** "Yes" means that there is information the Department must make available to the public pursuant to §54.1-2400.2.H of the Code of Virginia; please note that this may also include proceedings in which a finding of "no violation" was made. For additional information click on the "Yes" link above. "No" means no documents are available.*

Back to License Lookup

West Virginia
Board of
Medicine

Search: Details

Name	Title	Specialty	Certified	Location	Licensed Or Has Been Licensed In
Donna Lynn Burkett	MD	Family Practice	Verify Specialty Certification	128 Lakeside Avenue Suite 301 Burlington, VT (Other)	NC, OR, SC, VA, WV

License History

License Type	License Number	Status	License Date	Expiration Date
Medical Doctor	22710	Expired	05/14/2007	06/30/2014

Education History

School	Date Completed	Nature of Training
University Of North Carolina At Chapel Hill School Of Medicine	05/14/1995	Medical or Podiatric School
Uor Hs Ctr Hospital, Portland	6/30/1998	Post-Graduate Training

Physician Assistant(s) Collaboration

Name
No Current Supervision

Discipline/Board Action History

No Discipline Cases On Record

Malpractice History

No Malpractice Cases On Record

This data was retrieved on 10/9/2020.

Subject to **Terms and Conditions**. This site is a primary source for verification of license credentials consistent with Joint Commission and NCQA standards.

Oregon Medical Board
1500 SW 1st Ave
Suite 620
Portland, OR 97201
Phone: (971) 673-2700

Information current as of 10/09/2020 03:28:03 PM

Burkett, Donna Lynn, MD

MD License: MD20096

Originally Issued: 10/18/1996 **Basis:** USMLE

Current Status: Surrendered **Expedited Endorsement:** No

Status Effective: 12/31/2001

Other Licenses

License Number	Effective Date	Expiration Date	License Type
LL06837	07/01/1996	06/30/1997	MD Postgraduate License

Licensee Information

Gender: Female

Specialty : Family Practice

Specialty is self-reported by the licensee. It does not necessarily indicate specialty board certification.

Languages : English

Practice Location(s)

Street	City, State Zip	County	Phone
P.O. Box 489	Asheville, NC 28802	Buncombe	828-255-8900
Wnc Obgyn And Family Practice, 16 McDowell St	Asheville, NC 28801	Buncombe	828-255-8900

Education

School Name	Location	Degree Date	Degree Earned
U/NC SCH/MED	CHAPEL HILL, NC United States	05/14/1995	MD

Post-Graduate Training	School Name	Location	From	To	Specialty
Residency	OHSU	PORTLAND, OR United States	07/1996		Family Practice
Internship	OHSU	PORTLAND, OR United States	07/1995	06/1996	Family Practice

The licensee may have completed additional education or training programs. Only those that have been verified with the primary source are shown.

Board Orders

There are no current or prior Board orders or agreements on file for this licensee.

Malpractice

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; a self-insured entity; or a health maintenance organization. Claim reporting and disclosure requirements are governed by ORS 742.400.

The settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee, even though there is a closed malpractice claim on file. A payment in the settlement of a medical malpractice action does not create a presumption that medical malpractice occurred. This database represents information from reporters to date. Please note: Not all reporters may have submitted claim information to the Board.

For malpractice claim information, click here.

NATIONAL PRACTITIONER DATA BANK
NPDB
P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

5500000166972397
Process Date: 10/12/2020

BURKETT, DONNA LYNN - SELF-QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: BURKETT, DONNA LYNN
Date of Birth: [redacted] **Gender:** FEMALE
Delivery Address: [redacted] WASHINGTON, DC 20016-3596
Social Security Number: [redacted] **DEA:** BB5102772, FB4170178, FB4132015
NPI: 1760445506 **UPIN:** G86729
License: PHYSICIAN (MD), 42.0012729, VT, GENERAL PRACTICE/FAMILY PRACTICE
PHYSICIAN (MD), 16261, NH, GENERAL PRACTICE/FAMILY PRACTICE
PHYSICIAN (MD), MD19833, ME, GENERAL PRACTICE/FAMILY PRACTICE
Professional School(s): UNC CHAPEL HILL SCHOOL OF MEDICINE (1995)
OREGON HEALTH SCIENCE UNIVERSITY SCHOOL OF MEDICINE (1998)

B. PAYMENT INFORMATION

Credit Card Information: [redacted]
NPDB Charge: $4.00 **NPDB Bill Reference Number:** N71975680
Transaction Date: 10/12/2020 **Additional Paper Copies Requested:** 0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 10/12/2020

The following report types have been searched:

Report Type	Result	Report Type	Result
Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceding cover page.

---------- No Reports Found Based on the Subject Information Submitted ----------

SECTION 14: DOCUMENT CHECKLIST

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Please keep a photocopy of any submitted documents for your records, as they will not be returned.

N/A **Authorization to Release Information Form**

The Board cannot discuss the status or details of your application with a third party, without a signed release from you authorizing the Board and its staff to communicate said matters.

☑ **Two (2) recent and identical passport type photos of the applicant's face (approx. 2" x 2") with the applicant's name printed on the back**

The photo must be original photos and cannot be computer-generated copies, or paper copies.

☑ **One (1) photocopy of a current government issued photo ID**

☑ **Criminal Background Check (CBC)** 10/14

To access the CBC form and instructions, go to https://dchealth.dc.gov/node/120532 or contact the CBC unit at (877) 783-4187.

☐ **Three (3) Character Reference Forms**

Must be completed by an MD or DO in good standing in a jurisdiction of the United States who has knowledge of the applicants abilities and qualifications to practice medicine. If you have completed your postgraduate training within three years of the date of this application, at least one (1) reference letter needs to come from the director of your post-graduate clinical training program and one(1) from a supervising physician of your post-graduate clinical training program.

☑ **AMA/AOA Profile** ordered 10/12 - to be sent directly. sent 10/14/20. order # 683746091

The profile should be submitted from the issuing institution.

☑ **Verification(s) of Licensure** VT ck&mail NH ck&mail

Verifications should be provided from the issuing jurisdiction(s) for each license identified in Section 10 of the application.

☑ **Medical School Transcripts** requested 10/9, expect by 10/16

Transcripts should be provided in a sealed envelope from the issuing institution for each school listed in Section 7.

☐ **Verification of Post-Graduate Training**

Verifications should be provided in a sealed envelope from the post-graduate institution for each program identified in Section 8 of the application. Each verification should be signed by the training program director or someone with authority to verify the applicant's participation in the identified post-graduate training program.

☑ **Examination Scores** requested from FSMB 10/12. Electronic to DC BoM

Examination scores must be received from the examining body.

N/A **ECFMG Certificate (for foreign-trained applicants only)**

N/A **Malpractice Claims Form (if responded "Yes" to screening question #2)**

Must submit all relevant court documentation (e.g., Complaint, Answer, and Final Order/Decision).

☑ **National Practitioner Databank (NPDB) Self Query Report** included printed electronic version 10/12

The Self-Query Report must be requested from the NBPD (https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp) no more than thirty (30) days prior to submission of the application.

The University of North Carolina School of Medicine
CB# 7000, 121 MacNider Bldg.
Chapel Hill, N.C. 27599-7000

Student Name: Donna Lynn Burkett
Date of Birth: [redacted]
MD Degree: 14-may-1995

Leaves of Absence: None Taken

FIRST YEAR

Course MEDI	Description	Hrs	Gr
	21-aug-1991 to 15-may-1992		
120	BIOCHEMISTRY	6	
121	CELL BIOLOGY	1	
122	HISTOLOGY	3	
123	IMMUNOLOGY	2	
124	MEDICAL EMBRYOLOGY	1	
125	GROSS ANATOMY I	4	
125	GROSS ANATOMY II	2	
126	INTRO TO MEDICINE	3	
127	MEDICINE & SOCIETY	3	
128	MICROBIOLOGY/VIROLOGY	5	
129	NEUROBIOLOGY	4	
130	MEDICAL PHYSIOLOGY	4	
133	INTRO TO PATHOLOGY	2	
	19-aug-1992 to 17-dec-1992		
131	BIOMED SELECTIVE	1	
	Overall First Year Grade		

SECOND YEAR

Course MEDI	Description	Hrs	Gr
	17-aug-1992 to 22-apr-1993		
220	EPIDEMIOLOGY	1	
221	MECHANISMS/DISEASE	13	
222	PATHOLOGY	8	
223	PHARMACOLOGY	3	
224	PHYSICAL DIAGNOSIS	3	
225	PSYCHIATRY	2	
226	GENETICS	1	
231	HUM & SOC SCI SEL	1	
233	MUSCULOSKELETAL	3	
234	MEDICAL PROBLEMS	3	
	21-jun-1993 to 24-jun-1993		
327	TRANSITION COURSE	0	
	Overall Second Year Grade		

THIRD YEAR CLERKSHIPS

Course	Description	StartDate	EndDate	Hrs	Gr
MEDI331	MEDICINE	28- jun - 1993	17- sep - 1993	12	
FMME330	FAMILY MEDICINE	27- sep - 1993	22- oct - 1993	4	
PEDS333	PEDIATRICS	25- oct - 1993	17- dec - 1993	8	
SURY335	SURGERY	03- jan - 1994	25- mar- 1994	12	
OBGN332	OBSTETRICS-GYNECOLOGY	27- jun - 1994	05- aug - 1994	6	
PSYY334	PSYCHIATRY	15- aug - 1994	23- sep - 1994	6	
	Overall Third Year Grade				

FOURTH YEAR ELECTIVES

Course	Description	StartDate	EndDate	Hrs	Gr
FMME206	FAMILY MEDICINE STUDIES I	06- jan - 1992	26- apr - 1992	3	
ACSM404	AMBULATORY CARE SEL-PEDS	28- mar- 1994	22- apr - 1994	6	
FMME407	FAMILY MED STUDIES II	25- apr - 1994	20- may- 1994	6	
CHPM499	COMMUNITY HEALTH PROJECT	23- may- 1994	24- jun - 1994	6	
AHEC438	(FMME 421) AI INPT. FAM MED-ASHEVILLE	26- sep - 1994	21- oct - 1994	6	
PSYY424	CHILD PSYCH & DEV DISORDER	24- oct - 1994	18- nov - 1994	6	
RADY401	GENERAL RADIOLOGY	21- nov - 1994	16- dec - 1994	6	
SOCM416	STUDIES IN MED HUMANITIES	30- jan - 1995	24- feb - 1995	6	
	Overall Fourth Year Grade				

27-jun-1995

Allison Spragle

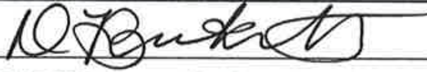
COPY

SECTION 15: PAYMENT AND MAILING INFORMATION.

Make your check or money order payable to "**DC Treasurer**".	Mail your completed application and check to:
A charge of sixty-five dollars ($65.00) will be imposed for dishonored checks (Public Law 89-208).	**Board of Medicine – MD/DO New Application**
	HRLA 1
	PO Box 37801
ALL FEES ARE NON-REIMBURSABLE.	**Washington, DC 20013**

SECTION 16: APPLICANT'S AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

SIGNATURE OF APPLICANT: 	**DATE:** 11/14/2020

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at https://oig.dc.gov.

Donna Burkett application

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SIGNATURE OF APPLICANT: [signature]	DATE: 11/14/2020

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Donna Burkett application

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1275
58-9106/2116

11/14/2020
DATE

PAY TO THE ORDER OF DC Treasurer $ 805.00

Eight hundred and five and no/100 DOLLARS

Security Features Details on Back.

Vermont FCU

Donna Burkett
FOR New MD license [signature]