EXHIBIT 5

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Richard S. Wilkinson, MD
Master Case No.: M2022-196
Document: Statement of Charges

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

If you have any questions or need additional information regarding the information that was withheld, please contact:

> Customer Service Center
> P.O. Box 47865
> Olympia, WA 98504-7865
> Phone: (360) 236-4700
> Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **RICHARD S. WILKINSON, MD** License No. MD.MD.00016229 Respondent.	**No. M2022-196** **STATEMENT OF CHARGES**

The Executive Director of the Washington Medical Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in Commission file number 2021-9863, 2021-10393, 2021-10901, 2021-11600, 2021-13535, and 2021-15189. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On November 15, 1977, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent is not board certified.

Summary

1.2 Respondent made numerous false and misleading statements on his public web site regarding the COVID-19 pandemic, COVID-19 vaccines, and public health officials that were harmful and dangerous to individual patients, generated mistrust in the medical profession and in public health, and had a wide-spread negative impact on the health and well-being of our communities. Respondent also provided negligent care to Patients A, B, C, D, E, F, and G to prevent or treat COVID-19 infections. For some of all of these patients, Respondent prescribed medications that are not indicated for a COVID-19 infection, failed to properly document adequate justification for the treatment in the medical record, failed to take a history or perform a physical examination, and failed to obtain appropriate informed consent.

Background

1.3 SARS-CoV-2 is a coronavirus that causes COVID-19, an infectious a respiratory disease that spreads mainly from person to person through respiratory

droplets produced when an infected person coughs, sneezes, or talks. Adults 65 years and older and people of any age with underlying medical conditions are at higher risk for severe illness. On January 22, 2020, The Center for Disease Control and Prevention (CDC) identified the first reported U.S. case of coronavirus in Washington State. Since then, nearly one million people in the U.S. have reportedly died because of COVID-19.

1.4 The United States Food and Drug Administration (FDA) has approved ivermectin tablets for use in humans for the treatment of some parasitic worms and approved ivermectin topical formulations for the treatment of external parasites such as head lice and scabies, and for skin conditions such as rosacea. The FDA has not approved ivermectin to treat severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infections that cause coronavirus disease 2019 (COVID-19).

1.5 Additionally, in the United States, the primary manufacturer of ivermectin, Merck & Co, Inc., issued guidance to clinicians regarding use of ivermectin in treating COVID-19. In Merck's statement to clinicians, it states that it has concluded ivermectin has no scientific basis for a potential therapeutic effect against COVID-19, no meaningful evidence for clinical activity or clinical efficacy in patients with COVID-19, and a lack of safety data in the clinical studies that have been conducted with COVID-19 patients.

1.6 The FDA has approved chloroquine phosphate for the treatment of malaria, and has approved hydroxychloroquine sulfate for the treatment of malaria and auto-immune conditions such as lupus and rheumatoid arthritis. On June 15, 2020, the FDA revoked the emergency use authorization that permitted chloroquine phosphate and hydroxychloroquine sulfate to be used to treat certain hospitalized patients for COVID-19. The FDA based its decision on emerging scientific data showing that these medications did not have an anti-viral effect, and that they posed a risk of serious cardiac adverse events and other potential serious side effects.

Public statements

1.7 Due to their specialized knowledge and training, licensed physicians possess a high degree of public trust and therefore have a powerful platform in society. Physicians also have an ethical and professional responsibility to practice medicine in the best interests of their patients and must share information that is factual, scientifically grounded, and consensus-driven for the betterment of public health. When

physicians spread inaccurate information, and rely on their status as licensed physicians to bolster their message, it is especially harmful as it threatens the health and well-being of our communities and undermines public trust in the profession and established best practices in care.

1.8 At all times relevant to this case, Respondent practiced medicine in a clinic that he owned. From June 2020 through at least May 2022, Respondent maintained a public web site on which Respondent identified himself as a licensed physician, promoted medical services he provided to patients in his clinic, and published a blog in which he provided medical information to the public. Between June 2020 and May 2022, Respondent made numerous false and misleading statements in his blog regarding the COVID-19 pandemic, COVID-19 vaccines, and public health officials. Among the numerous false and misleading statements Respondent made, or quoted others as making, were the following:

1.8.1 The pandemic is a scam;

1.8.2 Polymerase chain reaction (PCR) testing and the use of masks to reduce the spread of COVID-19 infection are useless;

1.8.3 Public health entities, including the U.S. Food and Drug Administration, the Washington State Department of Health, and the Yakima County Health Department, are providing false information and are not to be trusted;

1.8.4 Ivermectin and hydroxychloroquine are effective in preventing or treating a COVID-19 infection; and

1.8.5 COVID-19 vaccines are dangerous and kill people, comparing the push for vaccination with the murder of Jewish people in Hitler's Germany.

1.9 Respondent's public false and misleading statements regarding the COVID-19 pandemic, COVID-19 vaccines, and public health officials are harmful and dangerous to individual patients, generate mistrust in the medical profession and in public health, and have a wide-spread negative impact on the health and well-being of our communities.

Patient A and Patient B

1.10 On the morning of August 11, 2021, the daughter of Patient A and Patient B, both 84 years of age, called Respondent's office and told a staff member that both Patient A and Patient B were sick with fevers for the past three days. Respondent had been treating Patient A and Patient B, husband and wife, for many years. The daughter asked for help to prevent Patient A and Patient B from getting a COVID-19 infection. Respondent called and spoke to Patient A and Patient B later that day. After speaking with Patient A and Patient B on the phone, Respondent prescribed to both Patient A and Patient B the same medications: ivermectin, 15mg daily for three days, then every other day; azithromycin 5-day dose pack 250 mg; budesonide 0.5 mg/2 mL via nebulizer; and methyl-prednisolone 4 mg. Respondent prescribed these medications without seeing or physically examining Patient A and Patient B. Respondent noted in the medical record that the daughter of Patient A and Patient B was not present for this phone call, and instructed staff to call the daughter at the end of the day to coordinate the care.

1.11 Respondent did not document an appropriate history or medical decision-making regarding Patient A. The documented assessment consists of merely a billing code for four conditions, including COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed. Respondent did not document that he obtained informed consent from Patient A for his treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient A that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient A with evidence supporting the off-label use of ivermectin.

1.12 Respondent did not create a chart note for his treatment of Patient B for the August 11, 2021, phone call and Respondent's prescribing of the medications. Respondent did not document a sufficient rationale for prescribing any of the

medications he prescribed. Respondent did not document that he obtained informed consent from Patient B for her treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient B that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient B with evidence supporting the off-label use of ivermectin.

1.13 On August 15, 2021, both Patient A and Patent B went to the emergency department at a local hospital complaining of seven days of coughing, fevers, body aches, weakness, fatigue. Both Patient A and Patient B told the emergency department personnel that they both tested positive for a COVID-19 infection earlier in the week. Both Patient A and Patient B were admitted to the hospital and diagnosed with hypoxia respiratory failure caused by a COVID-19 infection. Both Patient A and Patient B spent the next eight days in the hospital and were both discharged on August 23, 2021.

Patient C

1.14 On August 28, 2021, the mother of Patient C, 17 years of age, took Patient C to the emergency department of a local hospital. Patient C had a fever, cough, body aches, and shortness of breath. Patient C had a history of hypertension, obesity, and asthma. Patient C used an inhaler for his asthma, but it was not helping him breathe. Both Patient C's mother and father were recently diagnosed with a COVID-19 infection. Patient C was not vaccinated. In the emergency department, Patient C was found to be hypertensive and had a COVID-10 infection. A chest x-ray was normal. Patient C was discharged from the emergency department with albuterol oral inhaler, benzonatate, ibuprofen, losartan, and ondansetron.

1.15 On August 30, 2021, Patient C's mother brought Patient C back to the hospital emergency department because Patient C had shortness of breath. Patient C's mother reported that Patient C's oxygen decreased to 89% at home. Patient C was found to be in no respiratory distress, was stabilized, and was discharged with dexamethasone, ibuprofen and acetaminophen.

1.16 On August 31, 2021, Patient C's mother took Patient C to see Respondent complaining of a bad cough, fever and a COVID-19 infection that was not getting better. Respondent prescribed 14 tablets of ivermectin 18 mg a day for four days, then every other day; zinc 200 mg a day; budesonide, nebulized hydrogen peroxide; a Medrol dose pack; nattokinase, three capsules daily; and minocycline 100 mg twice a day. Respondent did not take Patient C's vital signs or perform a physical examination of Patient C. Respondent did not document medical decision-making, or a sufficient rationale for prescribing any of the medications he prescribed to Patient C. Respondent did not document that obtained informed consent from Patient C or his mother for his treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient C and his mother that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, that Respondent provided Patient C with evidence supporting the off-label use of ivermectin, and that inhaled hydrogen peroxide has no effect on a COVID-19 infection and is dangerous.

1.17 That evening, Patient C's mother took Patient C back to the hospital emergency department because Patient C was suffering from increasing cough, shortness of breath, and an oxygen reading at home of 85%. Emergency department providers found Patient C to be hypertensive, had a pulse of 108, and that Patient C's oxygen saturation level ranged from 88% to 92%. Patient C was given supplemental oxygen and felt significant improvement; both his fever and his tachycardia resolved. Because of the intermittent hypoxia, the treating physician discussed with the mother whether Patient C should be admitted to the hospital or discharged home with supplemental oxygen. Patient C's mother chose to have Patient C discharged. Patient C was discharged with instructions that if he required more than two liters of oxygen by nasal cannula, he should return to the hospital for re-evaluation and likely admission.

1.18 On September 2, 2021, Patient C's mother took Patient C back to the hospital emergency department with shortness of breath. Patient C was febrile,

hypertensive and had tachycardia. Patient C reported his oxygen saturation at home dropped to 83-85% while sleeping, and with movement improved to 91%. Patient C was admitted to the hospital with a diagnosis of hypoxia and pneumonia due to a COVID-19 infection. Patient C was discharged two days later with increased supplemental oxygen, dexamethasone, albuterol, losartan, acetaminophen and ibuprofen.

Patient D

1.19 In the late evening on October 27, 2021, Patient D, 65 years of age, was taken by ambulance to the emergency department of a local hospital with shortness of breath and flu-like symptoms for several days. Patient D's oxygen saturation in the ambulance was 85%, but improved when given supplemental oxygen and IV dexamethasone in the emergency department. Patient D, who was not vaccinated, tested positive for a COVID-19 infection in the emergency department. Patient D was diagnosed with acute respiratory failure with hypoxia due to viral pneumonia from a COVID-19 infection. Patient D received supplemental oxygen and IV dexamethasone, but refused treatment with remdesivir and baricitinib. Patient D and his wife instead requested that Patient D be given ivermectin and explained that Patient D had a supply of ivermectin, hydroxychloroquine, and azithromycin at home that was prescribed by a naturopathic physician. Emergency department providers told Patient D and his wife that they would not provide ivermectin for a COVID-19 infection. At approximately 2 pm the next day, Patient D left the hospital against medical advice with a diagnosis of hypoxia and a COVID-19 infection.

1.20 Later that afternoon, Patient D went to see Respondent. In his chart note, Respondent states that Patient D was taking ivermectin. Respondent prescribed ivermectin 18 mg twice per day for five days, then once per day "until doing better." Respondent did not document what "until doing better" means. Respondent also prescribed azithromycin, prednisone, nebulized budesonide, heparin, zinc, melatonin, and vitamin C 2000mg every two hours.

1.21 Respondent did not document an appropriate history, a physical examination, or medical decision-making regarding Patient D. The documented assessment consists of merely a billing code for COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed. Respondent did not document that he obtained informed consent from Patient D for his

treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient D that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient D with evidence supporting the off-label use of ivermectin.

1.22 On November 3, 2021, Patient D returned to the hospital emergency department with shortness of breath, an oxygen saturation level of 90%, cough, fever, muscle pain and headache. Patient D told hospital personnel that based on Respondent's advice, he was not vaccinated against COVID-19, and had been taking ivermectin and supplemental oxygen at home, but his symptoms had worsened. Patient D was diagnosed with acute hypoxic respiratory failure. Patient D died in the hospital on November 14, 2021. The cause of death was pneumonia due to COVID-19 virus.

Patient E

1.23 In the early morning of September 8, 2021, Patient E went to the emergency department of a local hospital complaining of abdominal pain, nausea, dizziness, fever of 103.6, anorexia, and oxygen saturation readings at home in the 80s. Patient E was not vaccinated and was diagnosed with a COVID-19 infection. Patient E was given IV fluids and Zofran for nausea. Patient E was offered monoclonal antibodies, but refused. Patient E's vital signs improved, and she was discharged home with instructions to rest and quarantine for 14 days, to follow up with her primary care provider, and to return if her symptoms worsened.

1.24 Later that day, Patient E had a virtual visit with Respondent stating that she went to the hospital the night before, was diagnosed with a COVID-19 infection, and is not doing well. Respondent's record of this visit does not indicate that the visit was a virtual visit rather than an in-person visit, but Respondent told the Commission that he saw Patient E virtually via Zoom. Patient E told Respondent that she refused treatment with monoclonal antibodies. Patient E told Respondent she had been taking ivermectin, vitamin D, zinc, and nebulized hydrogen peroxide. Respondent prescribed to Patient E

ivermectin 18 mg twice per day for four days, then one tablet per day. Respondent also prescribed budesonide 0.5mg/2cc one vial in nebulizer, three times a day, zinc, azithromycin, and aspirin twice a day.

1.25 Respondent did not document an appropriate history or medical decision-making regarding Patient E. The documented assessment consists of merely a billing code for COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed. Respondent did not document that he obtained informed consent from Patient E for her treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, including the benefits of returning to the hospital to receive monoclonal antibodies which would reduce the risk of becoming seriously ill and requiring admission to the hospital; and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient E that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient E with evidence supporting the off-label use of ivermectin.

1.26 Late in the evening on September 9, 2021, Patient E went back to the hospital emergency department complaining of worsening shortness of breath, coughing, fatigue, fever, and chills. Patient E was admitted to the hospital with a diagnosis of acute hypoxic respiratory failure and pneumonia due to the COVID-19 infection. Patient E was given dexamethasone and supplemental oxygen. Patient E was discharged from the hospital six days later.

Patient F

1.27 On December 3, 2021, Patient F, 91 years of age, had a virtual visit via Zoom with Respondent. Respondent's record of this visit does not indicate that the visit was a virtual visit rather than an in-person visit, but Respondent told the Commission that he saw Patient F virtually via Zoom. The wife of Patient F was present with Patient F during the virtual visit with Respondent. Respondent had never seen or treated Patient F prior to this virtual visit. Respondent's record of this visit states that Patient F was exposed to COVID on Thanksgiving, that several family members of Patient F had

COVID, and that Patient F had a cough and a fever that had gone as high as 103. Respondent's record states that Patient F had no shortness of breath or trouble breathing, but ten minutes prior to the visit, his oxygen saturation level was reported to be 92%, and earlier in the morning it was reported to be 82%.

1.28 Respondent noted that Patient F had been taking ivermectin paste on a daily basis and was having "a lot of diarrhea." Respondent noted that the wife of Patient F said that Patient F one night had "almost a seizure or the shakes." Ivermectin paste is a veterinary formulation intended for use in animals and is dangerous when used by humans. Respondent did not advise Patient F not to take ivermectin paste.

1.29 Respondent diagnosed Patient F with a COVID-19 infection and prescribed ivermectin 15 mg twice per day for five days, then once per day "until doing pretty well." Respondent did not document what "doing pretty well" means. Respondent also prescribed supplemental oxygen, prednisone, Singulair, vitamin C, vitamin D, zinc, Tylenol, azithromycin, and melatonin. Respondent instructed Patient F and his wife to go to the hospital if he got significantly worse.

1.30 Respondent did not document a medical history of Patient F. At the time of the virtual visit with Respondent, Patient F suffered from dementia, hypertension, atrial fibrillation, and had an indwelling, dual-chamber pacemaker. Respondent did not document that Patient F had any of these conditions. Respondent did not ask Patient F whether he was vaccinated against COVID-19. Respondent did not document any medical decision-making. The documented assessment consists of merely a billing code for COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed.

1.31 In the chart note, Respondent wrote "informed consent re ivermectin." Respondent did not adequately document his obtaining of informed consent from Patient F. Appropriate documentation of informed consent would include documentation of a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection; and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin and the other medications for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient F that the FDA has not approved ivermectin for a COVID-19 infection,

that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient F with evidence supporting the off-label use of ivermectin.

1.32 On December 10, 2021, Patient F was taken by ambulance to the emergency department at a local hospital with respiratory distress. Upon arrival at the hospital, Patient F had an oxygen saturation level of 62%, and was immediately placed on bilevel positive airway pressure. Patient F was admitted to the hospital with a diagnosis of acute hypoxic respiratory failure due to COVID-19 pneumonia. Patient F was outside the window for treatment with remdesivir, and was given dexamethasone and albuterol. Patient F was offered treatment with baricitinib, but the family refused. Patient F's condition continued to decline. The family decided not to continue with the bilevel positive airway pressure and Patient F died on December 17, 2021.

Patient G

1.33 On December 8, 2021, Patient G, 87 years of age, went to see Respondent complaining of fever, low oxygen saturation, but no shortness of breath. Patient G told Respondent that her husband has a COVID-19 infection. Patient G told Respondent she was taking ivermectin paste. Ivermectin paste is a veterinary formulation intended for use in animals and is dangerous when used by humans. Respondent did not advise Patient G not to take ivermectin paste. Based on Patient G's symptoms and her husband's COVID-19 infection, Respondent assumed Patient G had a COVID-19 infection and prescribed ivermectin, 15 mg twice per day for five days, then once per day "until doing pretty well." Respondent did not document what "doing pretty well" means. Respondent also prescribed vitamin A, vitamin C, vitamin D, zinc, budesonide, prednisone, Singulair, cimedtidine, and promethazine.

1.34 Respondent did not document an appropriate history, a physical examination, or medical decision-making regarding Patient G. The documented assessment consists of merely a billing code for COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed. Respondent did not document that he obtained informed consent from Patient G for her treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19

infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient G that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient G with evidence supporting the off-label use of ivermectin.

1.35 On December 11, 2021, Patient G went to the emergency department at a local hospital complaining of shortness of breath. Patient G's oxygen saturation level was found to be 86%. Patient G was not vaccinated and tested positive for a COVID-19 infection. Patient G was given supplemental oxygen and dexamethasone, and admitted to the hospital with acute hypoxic respiratory failure due to COVID-19 pneumonia. Patient G requested ivermectin, but was declined. Patient G was released from the hospital six days later.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180 (1), (4), and (13), which provide:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. ...
>
> ...
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
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> ...
>
> (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
>
> ....

2.2 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

3. NOTICE TO RESPONDENT

The charges in this document affect the public health and safety. The Executive Director of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: June 7, 2022.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

Melanie de Leon

MELANIE DE LEON
EXECUTIVE DIRECTOR

ROBERT W. FERGUSON
ATTORNEY GENERAL

Kristin G Brew

KRISTIN G. BREWER, WSBA # 38494
SENIOR COUNSEL

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named below. RCW 42.56.240(1)

Patient A

Patient B

Patient C

Patient D

Patient E

Patient F

Patient G