Uniform Application for Physician Licensure

UA Username ckrajewski **Date Submitted** 4/6/2010
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Krjaewski
First Name Colleen Michele
Middle Name
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

Business
[ ] **Public Access** **Street** 3021 Berkshire Road
[X] **Mailing**
City Cleveland Heights **State/Province** OH **Zip Code** 44118
Telephone 2167785341
Fax
Email
Alternate Phone

Home
[X] **Public Access** **Street** 3021 Berkshire Road
[X] **Mailing**
City Cleveland Heights **State/Province** OH **Zip Code** 44118
Telephone 2167785341
Fax
Email
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

09/30/1981	Abington	Pennsylvania	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	Redacted		Are you a U.S. Citizen?	☐ Yes ☐ No
Gender	Social Security Number	NPID		

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** University of Pittsburgh School of Medicine
Address Alan Magee Scaife Hall
of the Health Professions

City Pittsburgh
State/Province PA
ZIP Code 15261
Country USA
Attendance Dates **From (mm/yyyy)** 07/2003 **To (mm/yyyy)** 05/2007
Graduation Date 5/1/2007
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name Metrohealth Medical Center
Hospital Address 2500 MetroHealth Drive

City Cleveland
State/Province Ohio
ZIP Code 44109
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2007 **To:** 06 /2011 **Successfully Completed?** ☐ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 3			☒ P	☐ F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure - MD or DO only - attach additional pages if necessary

	State/Province	**Type (MD, DO, etc)**	**License Number**	**Status**	**Issue Date**
1					

10. Chronology of Activities: List ALL activities (medical and non-medical) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2007 To: Month: Year: In Progress [X]	**Practice/Employment Name** MetroHealth Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 2500 Metrohealth Drvie **City** Cleveland **State/Province** Ohio **ZIP Code** 44109 **Country** USA **Position and Department** Resident-OB/GYN **% Clinical** 100% **Administrative** **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

90906

State Medical Board of Ohio

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Ohio Addendum to Application

Ohio Training Program

Are you or will you be in an accredited training program in Ohio? ☒ Yes ☐ No

If yes, identify name of training program and location:

MetroHealth Medical Center — Name of Hospital/Training Program
Cleveland, OH — City
Start Date: 7/07 — month/year

Specialty Boards

Name of Specialty Board (If none, enter "N/A")	Year Certified	Country
N/A		

TOEFL iBT

(International Medical School Graduates only)

THE TOEFL, TWE and ECFMG'S ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL iBT

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL iBT, regardless of citizenship or country of birth. Prior to July 2006 the Test of Spoken English was required with a minimum score of 40 (between 7/95-7/06) or 230 (prior to 7/95). The following are the only exceptions permitted under Ohio law:

	YES	NO
Have you completed two years of undergraduate college work in the United States?	☐	☐
During the five years immediately preceding the date of your application, have you: (Please note you must be able to answer "YES" to both parts of this question) Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States? **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?	☐	☐
Have you completed a Fifth Pathway program?	☐	☐
Have you passed the Clinical Skills Assessment examination given by ECFMG on or after July 1, 1998?	☐	☐

If you answered **NO** to all of the above questions, you **must** take the TOEFL iBT. Refer to the application instructions for contacting the Educational Testing Service. The Board cannot waive this requirement.

Applicant Name: Colleen Krajewski Date: 4/8/10

OK 5/6/10 KR

Ohio Addendum to Application

Preliminary Education Form

TO BE COMPLETED BY ALL APPLICANTS

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	Krajewski	Colleen	Michele	

High School or Equivalent

School Name: Garnet Valley High School

City: Glen Mills | State: PA | Country: USA

Dates Attended From: MO/YR / To: MO/YR /

Undergraduate College or Equivalent

School Name: University of Pittsburgh

City: Pittsburgh | State: PA | Country: USA

Dates Attended From: MO/YR / To: MO/YR / **Degree Received**: BS

School Name:

City: | State: | Country:

Dates Attended From: MO/YR / To: MO/YR / **Degree Received**:

Medical or Osteopathic School of Graduation

School Name: University of Pittsburgh School of Medicine

City: Pittsburgh | State: PA | Country: USA

Dates Attended From: MO/YR / To: MO/YR / **Degree Received**: MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 118653 DATE ISSUED: MAY 06 2010

This is to certify that this applicant has met the preliminary education requirements for study in conformity with the Statutes of Ohio and the regulations of the State Medical Board of Ohio

Applicant Name: Colleen M. Krajewski Date: 4/8/10

Ohio Addendum to Application
Additional Information
Medicine or Osteopathic Medicine

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	☐	☑
5.	Have you ever transferred from one graduate medical education program to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders.	☐	☑
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders.	☐	☑
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	☐	☑
22. a)	Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
b)	Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **You may answer "NO" to this question if** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.	☐	☑
a)	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?	☐	☑

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

b)	Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☑

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	☐	☑

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☑

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.	☐	☑

State Medical Board of Ohio

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Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **The recommending physician must sign this form in front of a notary**. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Robert Pollard MD, a licensed and practicing physician in the state of Ohio,
(recommending physician, print name *legibly*) (State of residence)

affirm that Krajewski, Colleen M. has been known to me personally for 3 years
(applicant, print name *legibly*)

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: Excellent
- His/her relationship with patients is: Excellent
- I rate his/her ability to work well with peers and medical staff as: Excellent
- His/her command of the English language is: Excellent
- Additional comments: Excellent

MEDICAL BOARD
APR 23 2010

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 2500 MetroHealth medical Center City: Cleveland State: OH Zip Code: 44109	Telephone Number (include area code)	(216) 778-5890
Signature of Recommending Physician (name stamps not acceptable)	R. Pollard MD	State of Licensure & License Number	35-074961

Signature of Applicant

Date Photo Taken: 4 / 2010
month/year

Subscribed and sworn to before me this 12th day of April, 2010.

Laurel Myers
Notary Public Signature

LAUREL MYERS
NOTARY PUBLIC • STATE OF OHIO
Recorded in Cuyahoga County
My commission expires Oct. 1, 2012

Date Commission Expires

NOTARY SEAL

90906

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Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **The recommending physician must sign this form in front of a notary**. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Thomas Frank MD (recommending physician, print name *legibly*), a licensed and practicing physician in the state of Ohio (State of residence),

affirm that Krajewski, Colleen (applicant, print name *legibly*) has been known to me personally for 3 years

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: Excellent
- His/her relationship with patients is: Excellent
- I rate his/her ability to work well with peers and medical staff as: Excellent
- His/her command of the English language is: Excellent
- Additional comments:

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 2500 Metrohealth Drive City: Cleveland State: OH Zip Code: 44109	Telephone Number (include area code)	216 778 5890
Signature of Recommending Physician (name stamps not acceptable)	Thomas Frank MD	State of Licensure & License Number	OH 35-052593

Signature of Applicant

Date Photo Taken: 4 / 2010 (month/year)

Subscribed and sworn to before me this 12TH day of April, 20 10.

Kim Malleo-Hall

Notary Public Signature

Date Commission Expires

Kimberly Malleo
Notary Public
My Commission Expires
6/26/2010

NOTARY SEAL

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary)

Krajewski
Applicant's Printed Last Name

Colleen M.
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

4/12/2010
Date of Signature

NOTARY

Dated 4-12-10 Signed Laurel Myers

State of Ohio County of Cuyahoga

SUBSCRIBED AND SWORN TO before me this 12th day of April 2010.

My commission expires: _____ (NOTARY PUBLIC SIGNATURE & SEAL)

LAUREL MYERS
NOTARY PUBLIC • STATE OF OHIO
Recorded in Cuyahoga County
My commission expires Oct. 1, 2012

Applicant Name: ~~Krjaewski~~, Colleen Michele Krajewski Date: 4/12/10

UA User : ckrajewski

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Colleen Michele Krajewski**
SSN:	Redacted
DOB:	**09/30/1981**
Packet ID:	**117450**
Recipient:	**State Medical Board of Ohio**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

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Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Colleen Michele Krajewski**	
Other Name Used:	**N/A**	
Gender:	**Female**	
Date of Birth:	**09/30/1981**	
Place of Birth:	**Montgomery County, PA USA**	
SSN:	Redacted	
Current Address:	**3021 Berkshire Road** **Cleveland Heights, OH 44118**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**N/A**
	Fax:	**N/A**
	Home:	**412-559-7009**
	Other:	**N/A**
Physical Description:	Height:	**5' 06"**
	Weight:	**129 lbs**
	Eye Color:	**Blue**
	Hair Color:	**Blond**
Physical Marks:	Description:	**Tattoo**
	Location:	**Back**
	Description:	**Scar**
	Location:	**Back**

Premedical Education (Reported by physician. Not verified by FCVS)**:**

Institution:	**University of Pittsburgh, Pittsburgh, PA 15260**
Dates of Attendance:	**08/1999 - 11/2002**
Degree Conferred/Issued:	**Bachelor of Science**

Medical Education:

Medical School:	**University of Pittsburgh School of Medicine** **G3 Thackeray Hall** **139 University Place** **Pittsburgh, PA 15260**
Dates of Attendance:	**08/18/2003 - 05/17/2007**
Date Degree Conferred/Issued:	**05/26/2007**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Graduate Medical Education:

Institution:	**MetroHealth Medical Center** **Department of Obstetrics and Gynecology** **2500 MetroHealth Drive** **Cleveland, OH 44109**
Training Level:	**1-2**
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2007 - 06/30/2009**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**3**
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2009 - 06/30/2010**
Completion:	**In Process**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Colleen Michele Krajewski
DOB:	09/30/1981
SSN:	Redacted
Packet ID:	117450
Request ID:	22055867

OMISSIONS

There are none identified.

DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant reports the degree/diploma was issued/conferred/awarded by Univ Pittsburgh Sch Med on 05/01/2007. The institution reports 05/26/2007.
Follow-Up:	FCVS has defined `graduation date` as the date the diploma was issued to the applicant by the medical school.

MISCELLANEOUS INFORMATION

There are none identified.

End of report for Colleen Michele Krajewski

Packet Id: 117450 Request Id: 22055867 Report Created By: HLOPEZ

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

June 17, 2010

FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: June 17, 2010
Your Reference Number: hlopez
FSMB Batch Number: BQ1775668

The following is a final report of the search results from the Board Action Data Bank as of June 17, 2010 for practitioners sub above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of June 17, 2010

Item	Name	DOB	School	Yr/Grad
1	Krajewski, Colleen Michele	09/30/1981	039070	2007

LICENSE HISTORY
State Board
No License Information Available

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 6/21/2010

State Queried For: State Medical Board of Ohio

Physician Name: Colleen Michele Krajewski

Date of Birth:

Year of Graduation:

Social Security Number:

ABMSU ID:

The data provided to FCVS by the ABMS does not include Specialty Certification information on file for this physician. This does not mean that the physician is not certified by one or more of the Member Boards of the American Board of Medical Specialties, as the data provided by ABMS does not include some physicians for which they have incomplete data.

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

Applicant's Signature (must be signed in the presence of a notary)

Kraiewski
Applicant's Printed Last Name

Colleen Michele
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

4/2/2010
Date of Signature

9/30/81
Date of Birth

Redacted
Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of Ohio County of Cuyahoga

SUBSCRIBED AND SWORN TO before me this 2nd day of April, 2010

My commission expires: 9/11/12

CHRISTINE E. LOTENERO
Notary Public, State of Ohio, Cuy. Cty.
My commission expires 9/11/2012

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: Christine E. Lotenero

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH
VITAL RECORDS

Certification of Birth

DATE OF BIRTH 09 [illegible]0-1981

FILE NO. 1130090-1981

DATE FILED 10-03-1981

COUNTY OF BIRTH MONTGOMERY

DATE ISSUED 03-23-2010

NAME SEX FEMALE
COLLEEN MICHELE KRAJEWSKI

FATHERS NAME
JOHN THOMAS KRAJEWSKI

MOTHERS MAIDEN NAME
CECILIA MICHELE BULLARD

SEAL
VERIFIED

Linda A. Caniglia
State Registrar

COMMONWEALTH OF PENNSYLVANIA ★ DEPARTMENT OF HEALTH ★

This is to certify that this is a true copy of the record which is on file in the Pennsylvania Department of Health, in accordance with the Vital Statistics Law of 1953, as amended.

WARNING: IT IS ILLEGAL TO DUPLICATE THIS COPY BY PHOTOSTAT OR PHOTOGRAPH

[illegible]/09

15628229

The information appearing on the certified copy of birth is exactly transcribed from information contained on the original birth certificate as filed with the Office of Vital Records.

If you wish to correct the certified copy issued, please complete the lower portion of this form in the presence of a notarizing official and forward to the Division of Vital Records, P.O. Box 1528, New Castle, Pa. 16103

PLEASE SUBMIT DOCUMENTARY EVIDENCE TO SUPPORT THE CHANGES REQUESTED SUCH AS A COPY OF A BAPTISMAL RECORD, EARLY SCHOOL RECORD, MILITARY RECORD, INSURANCE POLICY OR MARRIAGE LICENSE.

DATA	ORIGINAL RECORD NOW READS	CORRECTIONS DESIRED (print full names, dates, other)
NAME OF SUBJECT		
DATE OF BIRTH		
SEX		
OTHER ERROR		
OTHER ERROR		

SEAL

SUBSCRIBED AND SWORN TO BEFORE ME: MO. DAY YEAR

SIGNATURE OF PERSON ADMINISTERING OATH

By

DO NOT NOTARIZE UNLESS SIGNED BY SUBJECT (OR PARENT(S) IF UNDER AGE 18) MUST BE SIGNED IN PRESENCE OF NOTARY

FATHER'S SIGNATURE

MOTHER'S SIGNATURE

SUBJECT'S SIGNATURE

PRESENT ADDRESS

STREET

CITY STATE ZIP CODE

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

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 complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

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).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Pittsburgh School of Medicine

Complete Address: 532 Scaife Hall

Street Address: 3550 Terrace St.

City: Pittsburgh **State:** PA **ZIP Code (Postal Code):** 15261

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

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: Bachelors

Enrollment and Participation: Our records indicate that Krajewski, Colleen Michele
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 173 weeks of medical education on the following dates (mm/dd/yy):

From 08 / 18 / 2003 (Month / Date / Year) **To** 05 / 17 / 2007 (Month / Date / Year)

This individual (check one):

Was awarded the degree of M.D. on 05 / 26 / 2007 (Month / Date / Year)

Was NOT awarded a degree because:
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Kim Kirk (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available, this form must be notarized.

SEAL VERIFIED

Signature: Kim Kirk

Title: Asst. Records Officer

Date of Signature: 5/10/10

Phone: (412) 648-9239 **Fax:** (412) 624-0290

Email: KKirk@medschool.pitt.edu

KRhoades

VERIFICATION OF MEDICAL EDUCATI ..

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during **any part** of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response **YES** ☐ **NO** ☑

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
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			☐	☐

   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? Response **YES** ☐ **NO** ☑

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

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify 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? Response **YES** ☐ **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? Response **YES** ☐ **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?
   Response **YES** ☐ **NO** ☑

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

   _____

   _____

PROVIDED BY APPLICANT

Medical Education

School	039070 - University of Pittsburgh School of Medicine
Address	Alan Magee Scaife Hall
	Pittsburgh, PA 15261
	USA
Phone	
Dates	07/2003 - 05/2007 **Grad Date** 05/01/2007
Degree	MD - Doctor of Medicine
Program 6+ years:	N
Completed clinical clerkship in a country other than where my medical school was located:	N
Clinical Training	
Unusual Circumstances	
Leaves/Extensions	N
Probation	N
Disciplined	N
Negative Reports	N
Limitations	N

GRADUATE/PROFESSIONAL ACADEMIC TRANSCRIPT

UNIVERSITY OF PITTSBURGH

Page 1 of 2

Name : Colleen Michele Krajewski

Print Date : 2015-04-27
Name : Colleen Krajewski
Student ID : 1488737

Degrees Awarded

Degree : Bachelor of Science
Confer Date : 2002-12-14
Program GPA : 3.780
Degree Honors : Summa Cum Laude
Plan : Biological Sciences

Degree : Certificate
Confer Date : 2002-12-14
Degree GPA : 3.920
Plan : Conceptual Foundations of Medicine

Degree : Doctor of Medicine
Confer Date : 2007-05-25
Plan : Professional Program Medicine

Academic Program History

Program : School of Medicine
2003-05-27: Professional Program Medicine Major

Beginning of Medical School Record

Fall Term 2003-2004

Course	Description	Attempted	Earned Grade	Points
MED 5111	BASIC SCIENCE - SECTION 1	0.00 S		
MED 5122	PATIENT/DOCTOR RELATIONSHIP	0.00 S		

Spring Term 2003-2004

Course	Description	Attempted	Earned Grade	Points
MED 5119	BASIC SCIENCE - SECTION 2	0.00 S		
MED 5123	MEDIATING, IMAGING AND SOCIETY	0.00 S		
MED 5132	NORMAL PHYSICAL DIAGNOSIS	0.00 S		
MED 5145	HOST DEFENSE & MUSCULOSKELETAL	0.00 S		
MED 5150	AMBULATORY CARE - PART 1	0.00 S		
MED 5136	BASIC SCIENCE - SECTION 3	0.00 S		

Fall Term 2004-2005

Course	Description	Attempted	Earned Grade	Points
MED 5216	BODY FLUID HOMEOSTASIS	0.00 S		
MED 5250	AMBULATORY CARE - PART 2	0.00 S		

Spring Term 2004-2005

Course	Description	Attempted	Earned Grade	Points
MED 5214	CHEM STRS: NEUROSCIENCES	0.00 S		
MED 5221	DIGESTION/DYSPEPSIA/ENDOCRN/HEAL	0.00 S		
MED 5228	CHEM STRS/PE	0.00 S		
MED 5230	CLINICAL SKILLS	0.00 S		
MED 5238	MEDIATING, SERVICE, & SOCIETY 2	0.00 S		

Spring Term 2005-2006

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DALLAS, TX 75261-9850
United States

Samuel D. Conte
University Registrar

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GRADUATE/PROFESSIONAL ACADEMIC TRANSCRIPT

UNIVERSITY OF PITTSBURGH

Name Colleen Michele Krajewski

Course		Description	Attempted	Earned	Grade	Points
FM	5316	FAMILY MEDICINE CLERKSHIP		0.00	RS	
IMED	5332	ADULT INPATIENT MEDICINE		0.00	RS	
MED	5327	AMB CLINICAL CARE CLERKSHIP		0.00	RS	
OBGYN	5345	OBSTETRICS AND GYNECOLOGY		0.00	RS	
PEDS	5351	PEDIATRIC INPATIENT MEDICINE		0.00	S	
PSMS	5501	CLINICAL NEUROSCIENCES		0.00	RS	
SURG	5331	SURGERY AND PERIOPERATIVE CARE		0.00	RS	

Spring Term 2006-2007

Course		Description	Attempted	Earned	Grade	Points
MED	5401	MEDICINE ACTING INTERNSHIP		0.00	RS	
MED	5510	RHEUMATOLOGY AND IMMUNOLOGY		0.00	RS	
MED	5710	CLINICAL PHARMACOLOGY (IDS)		0.00	S	
OBGYN	5435	OBSTETRIC/GYNECOLOGY ELECTIVE		0.00	S	
OBGYN	5440	GYNECOLOGIC ONCOLOGY		0.00	H	
OBGYN	5885	Ob AND GYN RESEARCH		0.00	R	
OBGYN	5885	OB AND GYN RESEARCH		0.00	R	
OBGYN	5986	INDIVIDUAL STUDY		0.00	S	
PEDS	5460	NEONATOLOGY		0.00	H	
SURG	5461	RENAL TRANSPLANTATION		0.00	H	

Medical School Career Totals

CUM GPA : 0.000 CUM TOTALS : 0.00 0.00 0.000

End of Transcript

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Samuel L. Conte
University Registrar

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UNDERGRADUATE ACADEMIC TRANSCRIPT

UNIVERSITY OF PITTSBURGH

Name : Colleen Michele Krajewski

Print Date : 2010-04-27
Name : Colleen Krajewski
Student ID : 1288737

Degrees Awarded

Degree : Bachelor of Science
Confer Date : 2002-12-14
Degree GPA : 3.780
Degree Honors : Summa Cum Laude
Plan : Biological Sciences

Degree : Certificate
Confer Date : 2002-12-14
Degree GPA : 3.920
Plan : Conceptual Foundations of Medicine

Degree : Doctor of Medicine
Confer Date : 2007-05-26
Plan : Professional Program Medicine

Academic Program History

Program : College of Arts and Sciences
2000-08-30 : Pre-Medicine Major
2002-08-26 : Biological Sciences Major
2002-08-26 : Conceptual Fdn of Medicine Certificate

Beginning of Undergraduate Record

Fall Term 1999-2000

Course		Description	Attempted	Earned	Grade	Points
BIOSC	0050	FOUNDATIONS OF BIOLOGY LAB 1	1.00	1.00	B+	3.250
BIOSC	0715	HON FOUNDATIONS OF BIOLOGY I	3.00	3.00	A	12.000
Course Topic(s): UNIVERSITY HONORS COLLEGE						
CHEM	0110	GENERAL CHEMISTRY 1	4.00	4.00	A-	15.000
ENGLIT	0325	SHORT STORY IN CONTEXT	3.00	3.00	B-	9.450
PE	0001	UNIVERSITY ORIENTATION	1.00	1.00	S	
RPS	0618	MORALITY AND MEDICINE	3.00	3.00	A	12.000

Spring Term 1999-2000

Course		Description	Attempted	Earned	Grade	Points
BIOSC	0060	FOUNDATIONS OF BIOLOGY LAB 2	1.00	1.00	B	3.000
BIOSC	0716	HON FOUNDATIONS OF BIOLOGY 2	3.00	3.00	A-	11.250
Course Topic(s): UNIVERSITY HONORS COLLEGE						
CAS	0110	HEALTH FOCUS	3.00	3.00	S	
CHEM	0120	GENERAL CHEMISTRY 2	4.00	4.00	B+	13.080
RPS	0612	MIND AND MEDICINE	3.00	3.00	A	12.000
NEUROL	1003	UHC: INTRO TO NEUROSCIENCE	4.00	4.00	A+	16.000
Course Topic(s): UNIVERSITY HONORS COLLEGE						

Summer Term 1999-2000

Course		Description	Attempted	Earned	Grade	Points
BIOSC	1280	HUMAN ANATOMY AND PHYSIOLOGY	6.00	6.00	A-	22.500

Fall Term 2000-2001

Course		Description	Attempted	Earned	Grade	Points

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Samuel D. Conto
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United States

UNIVERSITY OF PITTSBURGH

Name: Colleen Michele Krajewski

BIOSC	0320	GENETICS	4.00	3.00 A-	12.000
CHEM	0310	ORGANIC CHEMISTRY 1	1.00	3.00 A+	3.000
CHEM	0330	ORGANIC CHEMISTRY LABORATORY 1	1.00	1.00 B+	3.250
HIST	1090	HISTORY MEDICINE & HEALTH CARE	3.00	3.00 A	11.250
	Course Topic(s): UNIVERSITY HONORS COLLEGE				
PHYS	0110	INTRODUCTION TO PHYSICS 1	5.00	3.00 B	08.000

Spring Term 2000-2001

Course		Description	Attempted	Earned Grade	Points
CHEM	0320	ORGANIC CHEMISTRY 2	3.00	3.00 A	12.000
CHEM	0340	ORGANIC CHEMISTRY LABORATORY 2	1.00	1.00 A	4.000
PHYS	0111	INTRODUCTION TO PHYSICS 2	3.00	3.00 A	12.000
SOC	1455	HEALTH AND ILLNESS	3.00	3.00 A	12.000
STAT	1000	APPLIED STATISTICAL METHODS	4.00	4.00 A	16.000

Summer Term 2000-2001

Course		Description	Attempted	Earned Grade	Points
PHYS	0212	INTRO TO LABORATORY PHYSICS	2.00	2.00 A	7.500

Fall Term 2001-2002

Course		Description	Attempted	Earned Grade	Points
BIOSC	0470	ECOLOGY	3.00	3.00 A-	11.250
BIOSC	1000	BIOCHEMISTRY	3.00	3.00 B+	9.750
BIOSC	1050	WRKSHP IN THE BIOLOGICAL SCIENCES	0.00	0.00 A	0.000
	REQ DESIGNATION: Writing Option				
CHE	0001	ELEMENTARY GERMAN 1	5.00	5.00 A	20.000
BIA	0010	INTRODUCTION TO ART	3.00	3.00 A	12.000
BIA	0012	INTRO TO ART/PAINTING FROM	1.00	1.00 A-	3.750
	REQ DESIGNATION: Writing Option				

Spring Term 2001-2002

Course		Description	Attempted	Earned Grade	Points
BIOSC	1850	MICROBIOLOGY	3.00	3.00 A	12.000
BIOSC	1855	INTRO TO MICROBIOLOGY LAB	1.00	1.00 A	4.000
CHE	1500	INTERMEDIATE	3.00	3.00 A	
GER	0002	ELEMENTARY GERMAN 2	5.00	5.00 A	20.000
HPS	0437	DARWINISM AND ITS CRITICS	3.00	3.00 A	12.000

Fall Term 2002-2003

Course		Description	Attempted	Earned Grade	Points
CAS	1506	STUDY ABROAD- AUSTRALIA	15.00	15.00 S	

Undergraduate Career Totals

CUM GPA:	3.769	CUM TOTALS:	113.00	123.00	150.000

Transfer Credits

Transfer Credit from Advanced Placement Exams

Applied Toward School of Arts and Sciences Program

Course Area GPA:	0.000	Transfer Totals:	10.00	10.00	0.000

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Samuel D. Conte

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University Registrar

TRANSCRIPT GUIDE

In September 2005, the University implemented a new student administration computer system resulting in the change to some historic terminology. Depending on the status of the student at the time the transcript is produced, the transcript labels may contain either current or historic terminology. These wording changes follow with the historic terminology in parentheses: Career (Level); Program (Academic Center); Plan (Major/Minor); Subplan (Area of Concentration); GPA (QPA).

GRADING POLICY

The following are grades and grade/quality points associated with each grade:

A+	4.00	C+	2.25
A	4.00	C	2.00
A-	3.75	C-	1.75
B+	3.25	D+	1.25
B	3.00	D	1.00
[redacted]	2.75	D-	0.75
		F	0.00

The following grades carry no grade/quality points:

G	Unfinished Course Work
H	Honors
HS	High Satisfactory
I	Incomplete
LS	Low Satisfactory
N	Audit
NC	No Credit
R	Resignation
S	Satisfactory
U	Unsatisfactory
W	Withdrawal

The following are discontinued grades:

K	Competent Attainment
P	Pass
Q	Qualified
WF	Withdrawal/Failing
Z	Invalid Grade
[redacted] **	No grade Reported

Note: Plus and minus grades were added to the University's grading system in the Winter Term 1975-1976.
For additional grade information please see the University grading policy on line at http://www.bc.pitt.edu/policies/policy/09/09-01-01.html

SPECIAL NOTATIONS (Applies only to students who attended prior to Fall Term 2005-2006).

1. Indicates that the course was repeated. The credits and quality points earned in this course are not used in the calculation of the QPA.
2. Indicates that the course was offered through the University Honors College
3. Indicates that the course was taken at one or more of the institutions participating in the University of Pittsburgh cross-registration program. Decode for the abbreviations are:

CAR	Carlow University (formerly Carlow College)
CMU	Carnegie-Mellon University
CHA	Chatham University (formerly Chatham College)
CCA	Community College of Allegheny County
DUQ	Duquesne University
LAR	La Roche College
PTS	Pittsburgh Theological Seminary
PPU	Point Park University (formerly Point Park College)
RMU	Robert Morris University (formerly RMC Robert Morris College)
SE	Seton Hill University (formerly Seton Hill College)
WC	Westmoreland County Community College

GPA/QPA POLICY: Prior to the Fall Term 2005-2006, the University cumulative Quality Point Average (QPA) was calculated based on all University of Pittsburgh courses relevant to the student's degree goal(s). Effective with the Fall Term 2005-2006, the cumulative Grade Point Average (GPA) is associated with credits completed at the Career Level. *For additional QPA/GPA information, please see the University GPA/QPA policy on line at http://www.bc.pitt.edu/policies/policy/09/09-01-02.html*

THREE-TERM CALENDAR: The University of Pittsburgh utilizes a three-term academic calendar which is equivalent to the semester-hour system. The first-professional programs operate on the semester calendar.

ACCREDITATION: The University of Pittsburgh is accredited by the Middle States Association of Colleges and Schools, Commission on Higher Education. Individual school or program accreditation may be verified by contacting the Dean's Office of the Academic Center/Program identified on the student's record.

DEGREES AWARDED FROM OTHER INSTITUTIONS: Any information displayed reflecting degrees awarded by other institutions should be verified with the awarding institution for accuracy

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974: In compliance with the Family Educational Rights and Privacy Act of 1974, as amended, this document has been released on the condition that the recipient will not permit any other party or agency to have access to the record without the written consent of the student.

COURSE NUMBERING SYSTEM
Effective Fall Term 1990-1991

0001-0999 and 7000-7999	Lower Level Undergraduate
1000-1999 and 8000-8999	Upper Level Undergraduate
2000-2999	Master Level Graduate
3000-3999	Doctoral Level Graduate
4000-4999	Noncredit
5000-5999	First Professional Programs (Medicine, Dental Medicine, Law)
6000-6999	Career Development Undergraduate
9000-9999	Career Development Graduate

Prior to Fall Term 1990-1991

0001-0099	Lower Level Undergraduate
0010-0099	First Year Sectioned Courses (Law)
0100-0199	Upper Level Undergraduate
0100-0399	Upper Level Electives (Law)
0200-0299	Master Level Graduate
0300-0399	Doctoral Level Graduate
0400-0499	Third Year Limited Enrollment Courses (Law)
0500-0599	First Professional Programs (Medicine and Dental Medicine)
0500-0699	Upper Division Seminars (Law)
0700-0799	Lower Level (General Studies)
0800-0899	Upper Level (General Studies)
0900-0999	Other
0900-0999	Activities for Credit (Law)

TO TEST FOR AUTHENTICITY The face of this transcript is printed on blue SCRIP-SAFE® paper with the name of the institution appearing in blue type over the face of the entire document.

UNIVERSITY OF PITTSBURGH• UNIVERSITY OF PITTSBURGH• UNIVERSITY OF PITTSBURGH • UNIVERSITY OF PITTSBURGH • UNIVERSITY OF PITTSBURGH • UNIVERSITY OF PITTSBURGH• UNIVERSITY OF PITTSBURGH• UNIVERSITY OF

ADDITIONAL TESTS: When photocopied, a latent security statement containing the words VOID VOID VOID appears over the face of the entire document. When this paper is touched by fresh liquid bleach, an authentic document will stain. A black and white or color copy of this document is not an original and should not be accepted as an official institutional document. ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE!

If you have any questions about this document, please contact the Registrar's Office at the appropriate campus:

Bradford Campus	(814) 362-7602
Greensburg Campus	(724) 837-7040
Johnstown Campus	(814) 269-7055
Pittsburgh Campus	(412) 624-7535
Titusville Campus	(814) 827-4482

06181608

The University of Pittsburgh

SCHOOL OF MEDICINE

UPON RECOMMENDATION OF THE FACULTY,
AND BY AUTHORITY OF THE BOARD OF TRUSTEES, CONFERS UPON

CHRISTINE REDOVAN
Notary Public
In And For The State Of OH
Recorded In Lorain County
My Comm. Exp. Dec. 11, 2011

04/26/07 I certify this to be a true & exact copy of the original document.
Christine Redovan

COLLEEN MICHELE KRAJEWSKI

THE DEGREE OF

DOCTOR OF MEDICINE

WITH ALL THE RIGHTS, PRIVILEGES AND RESPONSIBILITIES PERTAINING THERETO.
IN WITNESS THEREOF, THE SEAL OF THE UNIVERSITY AND THE SIGNATURES
OF THE AUTHORIZED OFFICERS ARE AFFIXED AT PITTSBURGH, PENNSYLVANIA.
MAY 26, 2007

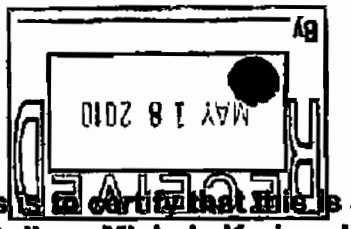
Ralph J Cappy
CHAIRMAN, BOARD OF TRUSTEES

Mark A. Nordenberg
CHANCELLOR

SEAL VERIFIED

James V. Maher
PROVOST

Arthur S. Levine
DEAN, SCHOOL OF MEDICINE



This is to certify that this is a true and accurate copy of the diploma issued to Colleen Michele Krajewski by the University of Pittsburgh.

Sincerely,

Carol Miller

Carol Miller, Supervisor
Transcripts & Certification

Section IV

Graduate Medical Education Training

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O.Box 619850, Dallas, TX 75261-9850

Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: MetroHealth Medical Center
Address: OBSTETRICS AND GYNECOLOGY
Cleveland, OH 44109

Attention: **Program Director**

Verification For: Name: Krajewski, Colleen Michele
DOB: 9/30/1981

Individual's Name on Record (if different from above):,

Packet ID:117450 Request ID:22055867 IFM CODE:12924

PGY:	1-2	**Specialty/Subspecialty:**	Obstetrics and Gynecology		
Program:	Residency	**From:**	7/1/2007	**To:**	6/30/2009
		Complete?:	Y	Accreditation:	ACGME
PGY:	3	**Specialty/Subspecialty:**	Obstetrics and Gynecology		
Program:	Residency	**From:**	7/1/2009	**To:**	6/30/2010
		Complete?:	P	Accreditation:	ACGME

Unusual Circumstances:

1. Did this individual ever take a leave of absence or break from his/her training?	**N**
2. Was this individual ever placed on probation?	**N**
3. Was this individual ever disciplined or placed under investigation?	**N**
4. Were any negative reports for behavioral reasons ever filed by instructors?	**N**
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reasons?	**N**

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Christine E Lotenero, BA
Title: Coordinator
Email: clotenero@metrohealth.org

Signature: *Christine E Lotenero, BA*
Date of Signature: 6/2/2010

Postgraduate Medical Education

Hospital	Metrohealth Medical Center
Affiliated School	
	2500 MetroHealth Drive
	Cleveland, OH 44109

Year(s)	1-4	**Program Type**	Residency
Complete?	In progress	**Specialty/Subspecialty**	Obstetrics and Gynecology
Dates	07/2007 - 08/2011		

Unusual Circumstances	
Leaves/Extensions	N
Probation	N
Disciplined	N
Negative Reports	N
Limits	N

Section V

Examination History/Score Transcripts

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

USMLE
United States Medical Licensing Examination™

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 – Telephone (817) 868-4041

Date: 05/21/2010

Recipient:
Federation Credentials Verification Service
ATTN: FCVS
Euless, TX 76039

Packet ID: 117459

Examinee: Krajewski, Colleen Michele
Alt Name(s):

Examinee ID#: 3165921720
Date of Birth: 09/30/1981

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

		Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
06/29/2005	Pass	220	182	89	75	

USMLE STEP 2

Clinical Knowledge (CK)

		Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
12/27/2006	Pass	212	182	86	75	

Clinical Skills (CS)*

		Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
12/20/2006	Pass					

USMLE STEP 3

		Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
OHIO 12/18/2009	Pass	211	187	88	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

KRAJEWSKI

TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

6/15/2010

Colleen Michele Krajewski, MD
3021 Berkshire Rd.
Cleveland Heights OH 44118

Your application for Ohio licensure has been reviewed. As of this date, the following has not been completed/received:

We have not received your core credentials packet from the Federation Credentials Verification Service (FCVS). To inquire about the status of your core credentials packet contact FCVS at (888) 275-3287.

We have not received the Physician Profile from the American Medical Association (AMA). If you have already requested this information contact the AMA at (800) 665-2882 to inquire about the status of your profile. The AMA physician profile must be ordered from the AMA website at www.ama-assn.org/amaprofiles.

ALL RESPONSES MUST BE IN WRITING. NO INFORMATION WILL BE TAKEN BY PHONE.

Inquiries about the status of your application must be requested in writing or by emailing the Board at med.license@med.state.oh.us.

The application processing time is ordinarily 10 to 12 weeks after receipt of an application by the Board. An incomplete application or any unusual circumstances may delay processing time.

Failure to complete the application process within six months of receipt may result in abandonment of your application. Please be advised that application fee is neither refundable nor transferable should your application be abandoned.

Be sure to notify the Board, in writing, of any address change.

Sincerely,

Carolyn Mack
Licensure Assistant

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

9/23/2010

Colleen Michele Krajewski, MD
3021 Berkshire Rd.
Cleveland Heights OH 44118

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **096149** was issued on **09/23/2010** and will expire on **10/01/2012**.

Enclosed is your wallet card and wall certificate. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://med.ohio.gov in the "Licensee Profile and Status section. The website is updated immediately to reflect newly issued licenses.

The Ohio Medical Board operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. Enclosed is a chart and information outlining the staggered medical license renewal system and continuing medical education (CME) hours required. Renewal applications are mailed approximately six months prior to the date of expiration. CME information may also be obtained from the Board's website.

SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE. *A CHANGE OF ADDRESS FORM IS AVAILABLE ON THE BOARD'S WEBSITE.*

This notice authorizes you to make application for a U.S. Drug Enforcement Administration certificate of registration (controlled substance permit). To make such application, contact:

Drug Enforcement Administration (DEA)
431 Howard St.
Detroit, Michigan 48226
(800) 230-6844
www.deadiversion.usdoj.gov/

Any questions regarding the DEA registration must be directed to the DEA office.

Sincerely,

Kay L. Rieve
Administrative Officer

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

VERIFICATION OF LICENSURE

This is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 09/01/2011:

Identification Information

Name and Address:	Dr. Colleen Michele Krajewski 3021 Berkshire Road Cleveland Heights, OH 44118
Date of Birth:	09/30/1981
Place of Birth:	Abington, PA
School of Graduation:	**University of Pittsburgh School of Medicine**
Date of Graduation:	05/01/2007

License Information

Type of License:	Doctor of Medicine
License Number:	35. 096149
How Issued:	End USMLE
Original Licensure Date:	09/23/2010
Expiration Date:	10/01/2012
Status:	ACTIVE
Formal Disciplinary Action:	No

Richard A. Whitehouse
Executive Director

595534

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov/

APPLICATION FOR TRAINING CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

NOTE: Application fee is $75.00. Fees submitted are neither refundable nor transferable.

PERSONAL INFORMATION

Check only one: ☑ **MD** ☐ **DO**

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50. O.R.C.) It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760. or 4762., O.R.C. or as otherwise required by state or federal law.

U.S. Social Security Number: Redacted

Full Name **(Use no initials)**:

Last (Surname)	First	Middle	Suffix (Jr., II)
Krajewski	Colleen	Michele	

Maiden Name Or Other Names Used **(If none, enter "NONE")**:

Last (Surname)	First	Middle	Suffix (Jr., II)

Physicians Address **(Be sure to notify the Board of any change in address)**:

Number & Street			
623 Gettysburg Street			
City	**State**	**Zip Code**	**Country**
Pittsburgh	PA	15206	USA

TRAINING PROGRAM INFORMATION

Training Program Address **(Hospital in Ohio where you will be starting your training)**:

Hospital & Department		
MetroHealth Medical Center, Department of Obstetrics + Gynecology		
Number & Street		
2500 MetroHealth Drive		
City	**State**	**Zip Code**
Cleveland	OH	44109-1998

Dates of Training:

Beginning Date: Mo/Day/Yr 7/1/07

Ending Date: Mo/Day/Yr 6/30/11

J-1 and H-1B VISA

To be completed by International medical school graduates only:

Are you currently applying for a J-1 or an H-1B Visa? ☐ YES ☐ NO

If YES check which one? ☐ J-1 ☐ H-1B

OHIO STATE MEDICAL BOARD

MAY 14 2007

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MEDICAL OR OSTEOPATHIC EDUCATION

Medical or Osteopathic School of Graduation:

School Name: University of Pittsburgh School of Medicine
City: Pittsburgh | State: PA | Country: USA

Dates Attended: From: Mo/Yr 8 / 03 To: Mo/Yr 5 / 07

Degree Received: MD Date Received: Mo/Day/Yr 5 / 21 / 07

Other Medical or Osteopathic Schools Attended **(If none, enter "NONE")**

School Name:
City: | State: | Country:

Dates Attended: From: Mo/Yr / To: Mo/Yr /

Reason degree not received at this school:

FIFTH PATHWAY PROGRAM

Fifth Pathway Program **(if none, enter "NONE")**:

Hospital or Institution: NONE
Name of Medical School:
City: | State: | Country:

Dates Attended: From: Mo/Yr / To: Mo/Yr /

ECFMG CERTIFICATE

To be completed by International medical school graduates only:

Do you have a valid ECFMG certificate? ☐ YES ☐ NO

Number:_____ Date Issued: Mo/Day/Yr / / Expires: Mo/Day/Yr / /

Applicant Name: Colleen M. Krajewski Date: 4/24/07

OHIO STATE MEDICAL BOARD
MAY 14 2007
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PHYSICAL DESCRIPTION

Staple a recent (taken within the last six months) passport-type **COLOR** photograph of applicant in the space provided below. Black and white photographs cannot be accepted.

Birth Date: Mo/Day/Yr 9/30/81

Birth Place: City Abington State PA Country USA

Gender: ☐ Male ☐ Female For statistics only (optional)

PHYSICAL DESCRIPTION

Height 5'6"
Weight 115 lb
Hair Color Blonde
Eye Color Blue
Identifying Marks
L-4-5 Discectomy Scar on lower back

THE UNITED STATES & CANADA

List ALL states/provinces, whether the license is current or not, in which you are or have been licensed, including temporary, educational permits, limited licenses, etc., to practice medicine and surgery or osteopathic medicine and surgery. Indicate license number, date of issuance and the type of license. If additional space is needed, attach an extra sheet. **(If none, enter "NONE")**

STATE/PROVINCE	ISSUE DATE	LICENSE #	TYPE OF LICENSE	LICENSE CURRENT
	MO/YR		*✓ONLY ONE*	*✓ONLY ONE*
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:

Applicant Name: Colleen M. Krajcovic Date: 4/24/07

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES

List ALL activities in chronological order from the date of medical school graduation to the PRESENT time, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", as well as your permanent home address for that time period.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did "locum tenens", you must list all hospitals where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets.

☑ **Check here if you are a new graduate (within 3 months). You DO NOT need to complete this form.**

From Month/Year	Hospital, University, Other or non-working activity	Position & Department	%Clinical
/	Complete Street Address		
To Month/Year	Number & Street		%Admin.
/	City State/Country Zip Code		

From Month/Year	Hospital, University, Other or non-working activity	Position & Department	%Clinical
/	Complete Street Address		
To Month/Year	Number & Street		%Admin.
/	City State/Country Zip Code		

From Month/Year	Hospital, University, Other or non-working activity	Position & Department	%Clinical
/	Complete Street Address		
To Month/Year	Number & Street		%Admin.
/	City State/Country Zip Code		

From Month/Year	Hospital, University, Other or non-working activity	Position & Department	%Clinical
/	Complete Street Address		
To Month/Year	Number & Street		%Admin.
/	City State/Country Zip Code		

From Month/Year	Hospital, University, Other or non-working activity	Position & Department	%Clinical
/	Complete Street Address		
To Month/Year	Number & Street		%Admin.
/	City State/Country Zip Code		

OHIO STATE MEDICAL BOARD

Applicant Name: Colleen M. Krajewski Date: 4/24/07

MAY 1 4 2007

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
ADDITIONAL INFORMATION

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a ***separate sheet of paper (DO NOT write explanations on these pages)***. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	☐	☑
5.	Have you ever transferred from one graduate medical education program to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑

Applicant Name: Colleen M. Krajewski Date: 4/24/07

OHIO STATE MEDICAL BOARD

MAY 14 2007

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		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
14.	Have you ever been denied, or have you ever surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. ***Photocopies will not be accepted***.	☐	☑
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? Please be advised that you are required to submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. ***Photocopies will not be accepted***.	☐	☑
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, you must complete the enclosed malpractice claim information form. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

Applicant Name: Colleen M. Krajewski Date: 4/24/07

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain.	☐	☑
22. a)	Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
b)	Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

* *

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☑
a)	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	☐	☑

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

b)	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	☐	☑

Applicant Name: Colleen M. Krajewski Date: 4/24/07

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	☐	☑
	If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		
	b) Are the limitations or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? if yes, please explain.	☐	☑

* *

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances. If yes, please explain.	☐	☐

Applicant Name: Colleen M. Krajewski Date: 4/24/07

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF: PENNSYLVANIA

COUNTY OF: ALLEGHENY

I, Colleen M. Krajewski, hereby certify under oath that I am the person named in this application for a training certificate in the State of Ohio; that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

I further state that by filing this application for a training certificate in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a training certificate in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a training certificate and that any fee I submitted is neither refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that I must limit my activities under the certificate to the programs of the hospitals or facilities for which the training certificate is issued; and that I may train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program.

I further understand that issuance of a training certificate in the State of Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

Colleen M. Krajewski
Signature of Applicant

Subscribed and sworn to before me this 24th day of April 20 07.

Mary Lou Sosso
Signature of Notary Public

(NOTARY SEAL)

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Mary Lou Sosso, Notary Public
City Of Pittsburgh, Allegheny County
My Commission Expires Apr. 3, 2009
Member, Pennsylvania Association of Notaries

Date Commission Expires

OHIO STATE MEDICAL BOARD

THIS FORM CANNOT BE FAXED

MAY 14 2007

RECEIVED

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov/

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
CERTIFICATION OF TRAINING PROGRAM

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by the Ohio training program in which I will be training. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name of Applicant: Krajewski (Last) Colleen (First) Michele (Middle) (Suffix (Jr., II))

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: METROHEALTH MEDICAL CENTER

Training Program Address: RESIDENCY SUPPORT OFFICE
2500 METROHEALTH DR., A107 (Street Address)
CLEVELAND, OHIO 44109-1998 (City / State / Zip Code)

Type of Program (check only one): ☒ Intern ☐ Resident ☐ Clinical Fellow

Specialty (*see reverse side*): OB/GYN

CERTIFICATION DATES - Indicate the month, day and year for both the beginning and ending dates in which the training certificate is to be issued. THE DATES ARE NOT TO EXCEED ONE YEAR. If the application is received prior to the date of the appointment, the appointment date will be used. If the application is received after the appointment date, or is not completed until after the appointment date, the completion date will be the date the certificate will become effective.

Dates of Training ***(not to exceed one year)***:

Beginning Date: MO/DAY/YR 07/01/07

Ending Date: MO/DAY/YR 06/30/08

I hereby certify that I have checked the credentials of the above applicant, that the statements, as completed, are true to the best of my knowledge and he/she is of good moral character. I further certify that he/she will limit his/her practice and training within the physical confines of the hospital, or facilities for which the training certificate to practice is sought and that he/she will practice only under the supervision of the attending medical staff of such hospital or facility for which the training certificate to practice is granted. I hereby recommend that the above applicant be granted the certificate herein applied for.

HOSPITAL SEAL

(If hospital has no seal, indicate and have form notarized)

Signature of Medical Director or Program Director

Charles Emerman, MD
Name (please print)

April 27, 2007
Date

OHIO STATE MEDICAL BOARD

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MAY 14 2007

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State Medical Board of Ohio

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1A - VERIFICATION OF MEDICAL EDUCATION
TO BE COMPLETED BY LCME OR AOA ACCREDITED SCHOOLS ONLY

THIS FORM IS NOT TO BE COMPLETED PRIOR TO GRADUATION

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by any medical or osteopathic schools I have attended. Please complete this form and return it *directly* to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name: Krajewski (Last) Colleen (First) Michele (Middle) _____ (Suffix (Jr., II))

Name of Medical/Osteopathic School: University of Pittsburgh School of Medicine

Location: Pittsburgh (City) PA (State)

I hereby authorize the above named medical/osteopathic school to furnish the information below to the State Medical Board of Ohio.

Colleen M. Krajewski (Signature of Applicant) 4/21/07 (Date)

THIS SECTION TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that Krajewski (Last) Colleen (First) M. (Middle) _____ (Suffix (Jr., II))

attended medical/osteopathic school from 8/18/03 (mo/day/yr) to 5/17/07 (mo/day/yr)

This individual *(check one)*:

☑ was awarded the degree of M.D. on 5/26/07 (mo/day/yr)

☐ was not awarded a degree (please attach an explanation)

I, certify that the above information is an accurate account of the above named individual's official records maintained and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL

(If your institution does not have an Official seal, please Indicate and have form notarized)

Joanne K Colligan (Signature)

JOANNE K COLLIGAN (Name (please print))

Asst School Registrar (Title)

5/26/07 (Date)

OHIO STATE MEDICAL BOARD

THIS FORM CANNOT BE FAXED

MAY 29 2007

RECEIVED

Date Posted: 5/30/2008 12:22:30 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

MAIN

3021 Berkshire Road
Cleveland Hts, OH 44118
Cuyahoga County
United States of America
412-559-7009
ckrajewski@metrohealth.org

License Information

License Number	57.013534
License Name	Colleen Krajewski

Fees

Relicensure Fee	$35.00
	========
Total Fees	**$35.00**

TC-Change programs

1. Are you currently training at the Training program previously listed?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have you been disciplined or notified of an investigation of you by your training program for other than academic performance?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints

against you?

. . . . . NO

5. Have you had any clinical privileges or other authority to practice suspended or revoked by any institution or program or have you been placed on probation for any reason other than academic performance?

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 6/17/2009 3:07:58 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	57.013534
License Name	Colleen Krajewski

Fees

Relicensure Fee	$35.00
	========
Total Fees	**$35.00**

TC-Change programs

1. Are you currently training at the Training program previously listed?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have you been disciplined or notified of an investigation of you by your training program for other than academic performance?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other authority to practice suspended or revoked by any institution or program or have you been placed on probation for any reason other than academic performance?

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or

alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 4/19/2010 10:40:41 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	57.013534
License Name	Colleen Krajewski

Fees

Relicensure Fee	$35.00
	========
Total Fees	**$35.00**

TC-Change programs

1. Are you currently training at the Training program previously listed?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have you been disciplined or notified of an investigation of you by your training program for other than academic performance?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other authority to practice suspended or revoked by any institution or program or have you been placed on probation for any reason other than academic performance?

. . . . . YES

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or

alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

State Medical Board of Ohio

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ACKNOWLEDGMENT OF APPLICATION FOR TRAINING CERTIFICATE

6/6/2007

Colleen Michele Krajewski
MetroHealth Medical Center
c/o Residency Support
2500 MetroHealth Drive
Cleveland OH 44109

HOSPITAL: **MetroHealth Medical Center**
Obstetrics & Gynegology

ACKNOWLEDGMENT LETTER EFFECTIVE DATE: 07/01/2007
ACKNOWLEDGMENT LETTER EXPIRES: 10/29/2007

Dear Doctor:

This is to notify you that your application for a training certificate was received by the Board on the above date and for the program indicated above.

Please be advised that you are hereby authorized to begin participation in the training program to which you have been appointed while your application is being processed. You are entitled to perform such acts as may be prescribed by or incidental to the internship, residency, or clinical fellowship program, but are not otherwise entitled to engage in the practice of medicine or surgery or osteopathic medicine and surgery in this state. You must limit your activities to the programs of the hospitals or facilities for which you have applied. You must train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program. **The authority granted by this letter will expire on the date indicated above.**

Applications are processed in the order received. An incomplete application or any unusual circumstances discovered during processing will result in deviation from this schedule. You will be notified if the application is incomplete or contains errors; or if there is difficulty in obtaining the independently requested recommendations.

Further, the Ohio Administrative Code provides that the Board may abandon an application if you fail to complete the application process within six months of initial application filing. Submitted fees will not be refundable or transferable.

Sincerely,

Penny E. Grubb
Chief, Licensure

9/21/2007

Colleen Michele Krajewski, MD
MetroHealth Medical Center
c/o Residency Support
2500 MetroHealth Drive
Cleveland OH 44109

NUMBER: **57-013534**
HOSPITAL: **MetroHealth Medical Center**
Obstetrics & Gynegology

DATES: **07/01/2007 - 06/30/2008**

Dear Doctor:

This is notify you that the above training certificate number has been issued to you in order for you to participate in the training program during the dates indicated above.

You are entitled to perform such acts as may be prescribed by or incidental to the internship, residency, or clinical fellowship program, but are not otherwise entitled to engage in the practice of medicine and surgery or osteopathic medicine and surgery in this state. You must limit your activities to the programs of the hospitals or facilities for which the training certificate is issued. You must train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program. Failure to abide by these limitations could result in the revocation of this certificate or criminal prosecution.

A training certificate shall be valid for one year, but may at the discretion of the Board be renewed annually for a maximum of five years. Renewal applications are mailed approximately April 1st for those who initiated their training on July 1st. Others will receive their renewal application accordingly.

Be sure to notify the Board, in writing, of any change in address within thirty days of the change. If you change programs before the end of the training year you must immediately notify the Board.

Sincerely,

Penny E. Grubb
Chief, Licensure

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

VERIFICATION OF LICENSURE

This is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 09/01/2011:

Identification Information

Name and Address:	Dr. Colleen Michele Krajewski MetroHealth Medical Center 2500 MetroHealth Drive Cleveland, OH 44109
Date of Birth:	09/30/1981
Place of Birth:	Abington, PA
School of Graduation:	**University of Pittsburgh School of Medicine**
Date of Graduation:	05/01/2007

License Information

Type of License:	MD Training Certificate
License Number:	57. 013534
How Issued:	
Original Licensure Date:	09/21/2007
Expiration Date:	06/30/2011
Status:	INACTIVE
Formal Disciplinary Action:	No

Richard A. Whitehouse
Executive Director

OHIO eLicense CENTER

Identification Information

[back]

Name	Dr. Colleen Michele Krajewski Birth Date: 9/1981 Birth Place: Abington, PA Birth Country:
Practice	No address information on file.
Residence	Cleveland Heights, OH 44118 County: Cuyahoga
Professional Education	School: 039070-University of Pittsburgh School of Medicine Graduated: 05/01/2007

License and Registration Information

Credential	License Type	Initial Licensure Date	Expiration Date	Status
35.096149	Doctor of Medicine	09/23/2010	10/01/2012	ACTIVE IN RENEWAL
57.013534	MD Training Certificate	09/21/2007	06/30/2011	FAILED TO RENEW

Specialties

OBSTETRICS & GYNECOLOGY

Specialty listings are voluntarily provided by the physician. They are not verified by the State Medical Board and do not confirm that the physician is Board certified by a professional specialty organization. To find out if a physician is certified by a specialty board, you should contact that board. Information and links to specialty boards can be found by clicking this green box.

Formal Action Information

No formal action exists.

The above is an accurate representation of information currently maintained by the State Medical Board of Ohio as of 9/4/2012. The JCAHO and the NCQA have informed the Board that they consider this on-line license status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards. This information is otherwise provided as a public service and no user may claim detrimental reliance thereon.

The State Medical Board utilizes the Federation Credentials Verification Service (FCVS) as an agent and partner in licensing physicians in Ohio. Physicians initially licensed in Ohio after February 1st, 1997 have had their medical education, post-graduate training and examination history primary source verified by FCVS. Therefore, the use of this website for documentation of primary source verification (PSV) of education and training meets current NCQA guidelines for those licensed after February 1, 1997. This statement, affirming that primary source verification of medical education and post-graduate training has been performed as part of the licensure process, should be printed out and retained in your files. Prior to February 1, 1997, the State Medical Board prime source verified the post-graduate training and examination history.