Professional Licensing Agency
402 West Washington Street
Room W072
Indianapolis, Indiana 46204

Michael R. Pence
Governor of Indiana
Nicholas W. Rhoad
IPLA Executive Director

December 1, 2015

Ronald Lee Kissel
14367 Elm Court
New Buffalo MI 49117

Dear Dr.Kissel:

We are in receipt of your application for medical licensure for the State of Indiana. Your application received a preliminary review by the board. The board found that your application for licensure does not meet the requirements according to 844 IAC 4-4.1, *et al.*

According to 844 IAC 4-4.5-9
Sec. 9. (a) In addition to complying with section 7 of this rule, an applicant for licensure by endorsement shall submit proof that the applicant satisfactorily completed the written examination provided by the:
(1) National Board of Medical Examiners (NBME);
(2) National Board of Osteopathic Medical Examiners (NBOME); or
(3) Federation of State Medical Boards of the United States, Inc. (FSMB).

(b) Acceptable examinations provided by an entity under subsection (a) are as follows:
(1) NBME.
(2) NBOME.
(3) Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA).
(4) Federation of State Medical Boards of the United States (FLEX).
(5) United States Medical Licensing Examination (USMLE).

(c) Endorsement from states requiring the NBME, NBOME, or FLEX will be honored if the examination was taken and passed in a manner that was, in the opinion of the board, equivalent in every respect to Indiana's examination requirements at the time it was taken.

According to your FLEX exam scores report, you did not obtain an average weighted score of 75. Please consider your application for licensure closed as you do not meet our examination requirements. This is not a denial by the Board, it is simply that you do not qualify for licensure.

Should you have further questions regarding this matter, please contact our office at (317) 234-2060 or via email at pla3@pla.in.gov.

Sincerely,

Elizabeth Sangar
Case Manager
Indiana Professional Licensing Agency
Medical Licensing Board

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

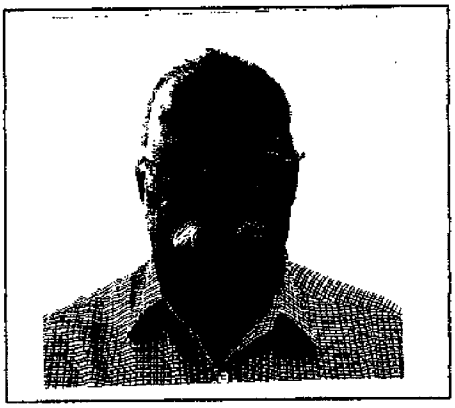
State Form 29495 (R17 / 6-13)
Approved by State Board of Accounts, 2013

MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

* Your Social Security number is being requested by this state agency in accordance with Indiana Code. Disclosure is mandatory and this record cannot be processed without it.

** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY	
Application fee: 250.00	Date fee paid (*month, day, year*): 4-22-15
Receipt number: 520629	Application number:
License number:	License issuance date (*month, day, year*):
Permit fee: 100.00	Date fee paid (*month, day, year*): 4.22.15
Receipt number: 520629	Permit number:
Permit issuance date (*month, day, year*):	



DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)	Check one:	Social Security number *
Kissel, Ronald Lee	☑ MD ☐ DO	

Address of practice (*number and street or rural route*): 14367 Elm Court

City, state, and ZIP code: New Buffalo, MI 49117

Telephone number (*daytime*)	Date of birth (*month, day, year*)	Ethnicity **	Race **	Gender **
	09/25/1949	Non-Hispanic	White	☑ Male ☐ Female

Mailing address (*number and street, city, state, and ZIP code*) (*if different from above*): N/A

E-mail address	National Provider Identifier number	ECFMG certificate number
	1851484356	N/A

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit? ☑ Yes ☐ No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

A foreign medical school must meet LCME standards at the time of graduation.

Name of school	Location	Date of graduation (*month, day, year*)
Autonomous University of Guadalajara	Guadalajara, Mexico	06/12/1975

Specialties	Board certification (*list ABMS certification*)
OB/GYN	N/A

RECEIVED
APR 22 2015
Indiana Professional Licensing Agency

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.

State where Board Exam was taken: _____

Examination	Most Recent Date Taken (month/year)	Results		Number of Attempts	Examination	Most Recent Date Taken (month/year)	Results		Number of Attempts
		Passed	Failed				Passed	Failed	
FLEX Pre-1985	1982	✓		2	NBOME Part II				
FLEX Component 1					NBOME Part III				
FLEX Component 2					COMLEX-USA Level 1				
LMCC - Single					COMLEX-USA Level 2, CE				
LMCC - Part I					COMLEX-USA Level 2, PE				
LMCC - Part II					COMLEX-USA Level 3				
NBME Part I					COMVEX				
NBME Part II					USMLE Step I				
NBME Part III					USMLE Step II, CS				
SPEX					USMLE Step II, CK				
NBOME Part I					USMLE Step III				

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
Northwestern University	Evanston, IL	08/1967 - 06/1971

MEDICAL / OSTEOPATHIC EDUCATION

A foreign medical school must meet LCME standards at the time of graduation.

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
Autonomous University of Guadalajara	Guadalajara, Mexico	08/1971 - 06/1975

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA

(Include ALL internships, residencies and / or fellowships)

All programs must have been ACGME accredited at the time of enrollment.

NAME OF PROGRAM	LOCATION	FROM (month, year)	TO (month, year)	ACGME / AOA / RC ACCREDITED?
St. Francis Hospital - OB/GYN Internship	Evanston, IL	07/1977	06/1978	☑ Yes ☐ No
St. Francis Hospital - OB/GYN Residency	Evanston, IL	07/1978	06/1981	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)	
GENERAL LOCATION	DATE (*month, day, year*)
Illinois	07/1975 - 06/1981
Arizona	07/1981 - 06/1982
Illinois	07/1982 - [redacted] 6/2009
Michigan	7/2009 [redacted] - Present

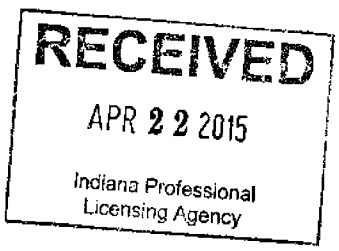
LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE (*month, day, year*)
Rush-Presbyterian, St. Luke's Medical Center (Chicago, IL)	Histology Teaching Assistant	07/1975 - 06/1976
Rush Medical College, Swedish Covenant Hospital (Chicago, IL)	Fifth Pathway Program	07/1976 - 06/1977
Private Practice (Scottsdale & Phoenix, AZ)	OB/GYN Physician	07/1981 - 08/1982
Scottsdale Memorial Hospital (Scottsdale, AZ)	Staff Privileges	07/1981 - 08/1982
Doctor's Hospital (Scottsdale, AZ)	Staff Privileges	07/1981 - 08/1982

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
IL	Physician (MD)	036.064944	07/1982	Active
OK	Physician (MD)	13314	09/1981	Expired
AZ	Physician (MD)	13057	10/1981	Expired
MI	Physician (MD)	4301101860	08/2012	Active

Ronald Kissel, MD
SSN: 329-40-0880

Application Addendum – Employment

Employer Name & Location	Responsibilities	Dates
St. Joseph's Hospital & Medical Center Phoenix, AZ	Staff Privileges	07/1981 – 08/1982
Private Practice Evanston, IL	OB/GYN Physician	09/1982 - 05/2000
Bethesda Hospital Chicago, IL	Staff Privileges	09/1982 – 07/1989
Rush North Shore Medical Center Skokie, IL	Staff Privileges	09/1982 – 07/1990
St. Francis Hospital Evanston, IL	Staff Privileges	09/1982 – 05/2000
North Shore Outpatient Surgicenter Evanston, IL	Staff Privileges	09/1989 – 05/2000
Rush North Shore Medical Center Skokie, IL	Staff Privileges	09/1997 – 05/2000
Affiliated Health Group, Ltd. Arlington Heights, IL	President, Medical Staff	06/2000 - 08/2006
Swedish Covenant Hospital Chicago, IL	Staff Privileges	11/2000 – 08/2002
St. Anthony Hospital Chicago, IL	In-House Attending	10/2002 – 05/2012
Norwegian American Hospital Chicago, IL	In-House Attending	09/2004 – 06/2008
Mt. Sinai Hospital Chicago, IL	In-House Attending	06/2012 – 12/2012
Harbor Country Gynecology New Buffalo, MI	OB/GYN Physician	01/2013 – 12/2013
Midwest Medical Point of Care Warren, MI	Home Health Practice	01/2014 - Present

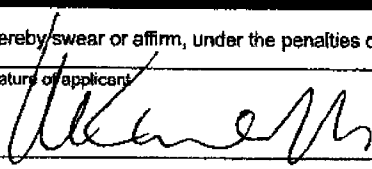


If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s), case information, detailed description of case / events and settlement amount, including court documents, if applicable. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	☐ Yes ☑ No
2. Have you ever been denied a license, certificate, registraton or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state *(including Indiana)* or country, or surrendered your license?	☐ Yes ☑ No
3. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner?	☐ Yes ☑ No
4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?	☐ Yes ☑ No
5. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,* (1) have you ever been arrested; (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	☐ Yes ☑ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☑ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☑ No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	☑ Yes ☐ No
9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐ Yes ☑ No
10. Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?	☐ Yes ☑ No
11. Have you ever been excluded from being a Medicare / Medicaid provider?	☐ Yes ☑ No
12. Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or any other reason during your medical education or post graduate training / residency program?	☐ Yes ☑ No
13. Have you practiced as a MD/DO either clinically or administratively in the last three (3) years?	☑ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)
	4/18/2015

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for medical licensure.

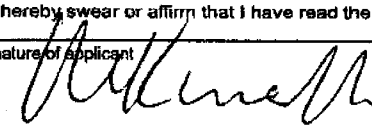
I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	Date signed (*month, day, year*)
	4/18/2015

LOSS INFORMATION SUPPLEMENT

PLEASE MAKE COPIES IF ADDITIONAL FORMS ARE NEEDED.

APPLICANT'S NAME : Ronald Kissel, M.D.

NOTE: ADDITIONAL DOCUMENTATION MAY BE REQUESTED AT THE MEDICAL PROTECTIVE COMPANY'S DISCRETION.

A. IS THE MATTER RELATED TO: ☒ A ☐ B ☐ C **FROM THE LOSS INFORMATION SECTION? (CHECK ONLY ONE)**

A. CURRENT OR PRIOR CLAIM.
B. COMPLICATION, INCIDENT, OR ADVERSE OUTCOME.
C. WRITTEN REQUEST FOR RECORDS.

B. PATIENT/CLAIMANT INFORMATION

S [redacted] LAST NAME U [redacted] FIRST NAME [redacted]0 AGE

C. DATE OF TREATMENT AND/OR SURGERY WHICH LED, OR COULD LEAD, TO ALLEGATIONS AGAINST YOU. 10 / 1991 MM YYYY

D. DATE OF NOTICE RECEIVED, IF APPLICABLE. 10 / 1992 MM YYYY

E. HAS THIS MATTER BEEN REPORTED TO YOUR CURRENT OR FORMER INSURER? ☒ YES ☐ NO

IF YES, DATE REPORTED TO YOUR CURRENT OR FORMER INSURER: 10 / 1992 MM YYYY

CURRENT OR FORMER INSURER NAME: ISMIE

IF NO, PLEASE EXPLAIN:

F. NAME OF ALL OTHER DOCTOR(S), HOSPITAL(S), OR HEALTH CARE PROVIDER(S), IF ANY, INVOLVED.

G. CURRENT STATUS: ☐ OPEN ☒ CLOSED

IF OPEN, INDICATE DOLLAR VALUE ESTABLISHED BY INSURER:

IF CLOSED:

1. DATE OF CLOSING: 12 / 1993
2. WAS A PAYMENT MADE? ☒ YES ☐ NO
   - A. IF YES, DID YOU CONSENT TO THE SETTLEMENT? ☒ YES ☐ NO
   - B. TOTAL AMOUNT OF SETTLEMENT OR AWARD:
   - C. TOTAL AMOUNT OF SETTLEMENT OR AWARD PAID ON YOUR BEHALF: $650,000

RECEIVED
APR 22 2015
Indiana Professional Licensing Agency

H. NATURE OF ALLEGATIONS OR POTENTIAL ALLEGATIONS:

CONDITION TREATED: Pregnancy
TREATMENT PROVIDED: NSVD
ALLEGED NEGLIGENCE: Erb's Palsy
ALLEGED INJURY: Erb's Palsy

I. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF ALL RELEVANT FACTS, INCLUDING, BUT NOT LIMITED TO, YOUR INVOLVEMENT IN THE TREATMENT AND/OR SURGERY:

Erbs palsy to the left upper extremity as a result of alleged failure to monitor the mother's diabetes and subsequently allowing a vaginal delivery.

Carol C Shubert 4/18/15

CAROL C SHUBERT
Notary Public, State of Michigan
County of Berrien
My Commission Expires 12-23-2019
Acting in the County of Berrien

4/18/15

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: Kissel (Last) Ronald (First) (MI)

A. Plaintiff's Name: S. (Last) _____ (First) _____ (MI)

If court case, Case Name & Case Number: _____

B. Your Involvement in the Care (Attending, Consulting, Etc.): Attending

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): Co-Defendant

D. Allegations, including Patient Outcome, if Available: Erb's Palsy to the left upper extremity as a result of alleged failure to monitor the mom's diabetes and subsequently allowing vaginal delivery.

E. Date of Incident (mm/yy): 10/91

F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): 12/93

Resolution Case: ☐ Dismissed ☒ Settlement out of Court ☐ Judgment ☐ Pending ☐ Arbitration ☐ Mediation ☐ Other

H. Amount Paid on Your Behalf (if any): $650,000.00

I. Professional Liability Insurer Name (if one was involved): ISMIE

J. Insurer Telephone Number: (312) 782-2749

K. Policy Number: _____

L. Insurer Address (Street, City, State, Zip Code):
20 N. Michigan Avenue, #700
Chicago, IL 60602

RECEIVED
APR 22 2015
Indiana Professional Licensing Agency

Signature: _____ **Date:** 4/18/2015

4/18/15

Carol C Shubert

CAROL C SHUBERT
Notary Public, State of Michigan
County of Berrien
My Commission Expires 12-23-2019
Acting in the County of Berrien

CompHealth

SUPPLEMENTAL CLAIM INFORMATION

Please supply the following information regarding any instance of claim, suit, or incident which may give rise to a claim whether dismissed, settled out of court, judgment or pending. Answer all questions completely. This form should be photocopied and filled out separately for each claim.

GENERAL INFORMATION

Applicant (Defendant's) Name *
Ronald L. Kissel, MD

Claimant (Plaintiff's) Name *
St

Date of alleged error	Date of Claim *
	01/1992

Indicate whether * ○ Claim ◉ Suit or ○ Incident that has been reported to your insurance carrier

Name of insurer	Agent	Phone
Ismie		

Location of court where original complaint was filed	Case number

Defendant's legal representative	Phone

Address	City	State	ZIP Code

Plaintiff's legal representative	Phone

Address	City	State	ZIP Code

STATUS OF COMPLAINT

*If closed, indicate whether: **

○ Court judgment Finding for ○ You ○ Plaintiff Date: _____ Determined by ○ Judge ○ Jury

◉ Out-of-court settlement Date of settlement: 12/1993

Amount paid on your behalf: $ 650,000 Compensation: $ _____

Punitive: $ _____ Total settlement amount: $ 650,000

○ Case dismissed ☐ Against YOU ☐ Against ALL DEFENDANTS Date: _____

If pending, indicate:

Claimant's settlement demand: $ _____ Defendant's offer for settlement: $ _____

Insurer's loss reserve: $ _____ Defense reserve: $ _____ Deductible: $ _____

Claim in suit ○ Yes ○ No If yes, amount asked in summons: $ _____ Compensation: $ _____ Punitive: $ _____

DESCRIPTION OF CLAIM

Provide enough information to allow evaluation

Incident location *
St. Francis Hospital

Alleged act, error, or omission upon which Claimant bases claim *
Erb's Palsy

Description of type and extent of injury or damage allegedly sustained *
Minor Erb's Palsy secondary to vaginal delivery and shoulder dystocia

Patient's condition at point of your involvement *
at time of delivery

Patient's condition at end of treatment *
Minor Erb's Palsy

Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done each time the patient was seen professionally (treatment and procedures provided). *

Alleged failure to monitor mother's gest diabetes
Allowed to deliver (labor of about 2 hours) vaginally with subsequent shoulder dystocia and a minor Erb's Palsy

Carol C Shubert
CAROL C SHUBERT
Notary Public, State of Michigan
County of Berrien
My Commission Expires 12-23-2019
Acting in the County of Berrien

Printed Name Ronald Kissel Signature DocuSigned by: Ronald Kissel 169E015BA4B54AC... Date 10/28/2013

4/18/15

Revised 2010

STATE OF MICHIGAN - DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

BOARD OF MEDICINE

PHYSICIAN

LICENSE

RONALD LEE KISSEL
14367 ELM COURT
NEW BUFFALO MI 49117

PERMANENT I.D. NO. 4301101860 EXPIRATION DATE 01/31/2016 3233342

STATE OF MICHIGAN - DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

BOARD OF PHARMACY

CONTROLLED SUBSTANCE LICENSE

RONALD LEE KISSEL
14367 ELM COURT
NEW BUFFALO MI 49117

PERMANENT I.D. NO. 5315057418 EXPIRATION DATE 01/31/2016 3234600

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FK4727941	12-31-2016	$731
SCHEDULES	**BUSINESS ACTIVITY**	**ISSUE DATE**
2,2N, 3,3N,4,5	PRACTITIONER	07-24-2014

KISSEL, RONALD
MIDWEST MEDICAL POINT OF CARE
8200 OLD 13 MILE ROAD
SUITE 106
WARREN, MI 48093-0000

Arizona Medical Board

General Information

Ronald L. Kissel
4500 Oakton St
Skokie IL 60076-3143

License Number: 13057
License Status: Expired
License Date: 10/02/1981
License Renewed: 10/02/1981
Due to Renew By:
If not Renewed, License Expires: 05/01/1986

Education and Training

Medical School:	UNIV AUTO DE GUADALAJARA, FAC DE MED Guadalajara Jalisco
Graduation Date:	06/12/1975
Area of Interest:	Obstetrics & Gynecology

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

Board Actions

None

This license information was last updated on: 04/23/2015

A person may obtain additional public records related to any licensee, including dismissed complaints and non-disciplinary actions and orders, by making a written request to the Board. The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

Please note that some Board Actions may not appear until a few weeks after they are taken, due to appeals, effective dates and

Board actions taken against physicians in the past 24 months are also available in a chronological list.

April 24, 2015

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MIKE ZIMMER
DIRECTOR

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF April 24, 2015

NAME: Ronald Lee Kissel **BIRTHDATE:** 09/25/1949

ADDRESS: 14367 Elm Court
New Buffalo MI 491170000

TYPE: Medical Doctor **ORIGINAL DATE:** 08/27/2012

LICENSE NUMBER: 4301101860 **STATUS:** Active **EXPIRATION DATE:** 01/31/2016

OBTAINED BY: Endorsement - Licensed >= 10 Years

EXAM DATE	EXAM TYPE	EXAM SCORE OR RESULT

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

This license information was last updated on: 4/23/2015

Board of Medical Licensure & Supervision
State of Oklahoma

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

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

Letter of Verification

April 24, 2015

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

Name:	RONALD LEE KISSEL
Address Date:	
Address 1:	800 AUSTIN
Address 2:	#201
Address 3:	
City, State, ZIP:	EVANSTON, IL 60202

Profession:	MEDICAL DOCTOR
Profession Type:	MD
License Number:	13314
License Date:	09/15/1981
Status:	Inactive
Status Class:	Expired License
Expiration Date:	06/30/1992
Endorsed By:	FLEX
Restricted To:	

Previous Licenses:

Type	Issued	Expired

Disciplinary Actions:

Date	Description

No Disciplinary Actions Taken

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

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

The Oklahoma State Board of Medical Licensure and Supervision certifies that the verification data displayed here is accurate according to the information stored in our database as of 04/23/2015.

Robyn Hall
Director of Licensing
(405) 848-6841 ext 113

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Bruce Rauner
Governor

Bryan A. Schneider
Secretary

Jay Stewart
Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

IPLA-Medical Examining Board
402 W Washington St Room W072
Indianapolis IN 46204

Licensee:	RONALD L KISSEL MD
License Number:	036.064944
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	07/30/1982
Expiration Date:	07/31/2017
License Status:	ACTIVE
License Method:	ENDORSEMENT-FLEX
Disciplinary History:	Has not been disciplined

RECEIVED
JUN 15 2015
Indiana Professional Licensing Agency

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

DEPT. OF FINANCIAL & PROFESSIONAL REGULATION SEAL DIV. OF PROFESSIONAL REGULATION

Jay Stewart #7
Director
Division of Professional Regulation

June 10, 2015
Date

Refer to the Department's Web Site at www.idfpr.com *to verify professional licenses via License Look-Up.*