88059

MEDICAL BOARD

Application for Physician Licensure

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 CANSINO

First Name CATHERINE

Middle Name DIANE

Suffix

Maiden Name

M.D. ☒ D.O. ☐

All other names used

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.

Practice Address

☑ Public Access

☐ Mailing

~~NORTHERN NAVAJO MEDICAL CENTER~~ ERROR

THE OHIO STATE UNIVERSITY

Street 456 W 10TH AVE, 2B CRAMBLETT

City COLUMBUS State OHIO ZIP Code 43210

Telephone (614) 293-3069

Fax

E-mail address ~~CATHERINE.CANSINO@IHS.GOV~~ ERROR

Alternate Phone

Home Address

☐ Public Access

☑ Mailing

Street 3793 CANDELARIAS LN NW

City ALBUQUERQUE State NM ZIP Code 87107

Telephone 443 465 9340

Fax

E-mail address CCANSINO@YAHOO.COM

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

01/18/1978	PHILADELPHIA	PENNSYLVANIA	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State	Birth Country

F (Gender)

REDACTED (Social Security Number)

Are you a U.S. Citizen? ☑ Yes ☐ No

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 (attach additional pages if necessary)

1. School Name: UNIVERSITY OF TOLEDO
   Address: 3045 ARLINGTON AVENUE
   City: TOLEDO
   State: OH
   ZIP Code:
   Country: USA
   Attendance Dates (From – To):
   Graduation Date:
   Degree: MD

2. School Name:
   Address:
   City:
   State:
   ZIP Code:
   Country:
   Attendance Dates (From – To):
   Graduation Date:
   Degree:

Applicant Name: CATHERINE CANSINO Date: 2/10/10

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 (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name JOHNS HOPKINS HOSPITAL
Hospital Address 600 N. WOLFE
City BALTIMORE
State MD
ZIP Code 21287
Country USA

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

Department/Specialty: OB/GYN

From: 07 / 2002 To: 06 / 2006 Successfully Completed? Yes ☑ No ☐ In Progress ☐
Month Year Month Year

2.Hospital Name JOHNS HOPKINS BAYVIEW MEDICAL CENTER
Hospital Address 4940 EASTERN AVE
City BALTIMORE
State MD
ZIP Code 21287
Country USA

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

Department/Specialty: OB/GYN FAMILY PLANNING

From: 07 / 2006 To: 06 / 2008 Successfully Completed? Yes ☑ No ☐ In Progress ☐
Month Year Month Year

Applicant Name: CATHERINE CANSINO Date: 2/10/10

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	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
State Board Exam _____ State		☐ P ☐ F	
FLEX Pre-1985		☐ P ☐ F	
FLEX Component 1		☐ P ☐ F	
FLEX Component 2		☐ P ☐ F	
LMCC – Single		☐ P ☐ F	
LMCC – Part I		☐ P ☐ F	
LMCC – Part II		☐ P ☐ F	
NBME Part I		☐ P ☐ F	
NBME Part II		☐ P ☐ F	
NBME Part III		☐ P ☐ F	
NBOME Part I		☐ P ☐ F	
NBOME Part II		☐ P ☐ F	
NBOME Part III		☐ P ☐ F	
SPEX		☐ P ☐ F	
COMVEX		☐ P ☐ F	
COMLEX		☐ P ☐ F	
USMLE Step I	6/2000	☑ P ☐ F	1
USMLE Step II	10/2001	☑ P ☐ F	1
USMLE Step III	10/2002	☑ P ☐ F	1

Applicant Name: CATHERINE CANSINO Date: 2/10/10

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 healthcare 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

1. State/Province NM Type MD (MD, DO, etc) License Number MD2008-0671 Status ACTIVE Issue Date 8/18/08
2. State/Province MD Type MD (MD, DO, etc) License Number D0064402 Status ACTIVE Issue Date EXPIRES 9/30/10
3. State/Province IL Type MD (MD, DO, etc) License Number 036.120284 Status INACTIVE Issue Date EXPIRED 7/13/08
4. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
6. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
7. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
8. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
9. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
10. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

Applicant Name: CATHERINE CANSINO, MD Date: 2/10/10

All Other Healthcare Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State _____ Type _____ License Number _____ Status _____ Issue Date _____

10. Chronology of Activities: Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school to the present date, leaving no time period unaccounted for in your resume. Use an additional page to account for non-professional activities and any other gaps in time between professional experiences, including military duty.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: 7/2002 Year: _____ To: Month: 6 Year: 2006	Practice/Employment Name JOHNS HOPKINS UNIVERSITY Practice/Employment Address 600 N WOLFE City BALTIMORE State MD ZIP Code 21287 Country USA Position and Department HOUSESTAFF OB/GYN % Clinical 100 % Administrative _____ Employment ☑ Staff Privileges ☑ Affiliation ☑ Other _____
2. From: Month: 7 Year: 2006 To: Month: 6 Year: 2008	Practice/Employment Name JOHNS HOPKINS BAYVIEW Practice/Employment Address 4940 EASTERN AVE City BALTIMORE State MD ZIP Code 21224 Country USA Position and Department FELLOW % Clinical 10? % Administrative _____ Employment ☑ Staff Privileges ☑ Affiliation ☑ Other _____

Applicant Name: CATHERINE CANSINO Date: 2/10/10

3.

From: Month: 7 Year: 2008

To: Month: CURRENT Year:

Practice/Employment Name: JHPIEGO
Practice/Employment Address: 1615 THAMES ST
City: BALTIMORE
State: MD
ZIP Code: 21231 Country: USA
Position and Department: SR. TECH ADVISOR % Clinical: % Administrative: 100
Employment ☑ Staff Privileges ☐ Affiliation ☐ Other:

4.

From: Month: 11 Year: 2008

To: Month: CURRENT Year:

Practice/Employment Name: CURTIS BOYD, MD, PC
Practice/Employment Address: 522 LOMAS BLVD NE
City: ALBUQUERQUE
State: NM
ZIP Code: 87102 Country: USA
Position and Department: CONTRACT PHYSICIAN % Clinical: 100 % Administrative:
Employment ☑ Staff Privileges ☐ Affiliation ☐ Other:

5.

From: Month: 2 Year: 2009

To: Month: 5 Year: 2009

Practice/Employment Name: COMP HEALTH
Practice/Employment Address: PO BOX 713100
City: SALT LAKE CITY
State: UT
ZIP Code: 84171-3100 Country: USA
Position and Department: CONTRACT PHYSICIAN % Clinical: 100 % Administrative:
Employment ☑ Staff Privileges ☐ Affiliation ☐ Other:

6.

From: Month: 10 Year: 2009

To: Month: CURRENT Year:

Practice/Employment Name: NORTHERN NAVAJO MEDICAL CENTER
Practice/Employment Address: PO BOX 160, HIGHWAY 491 N
City: SHIPROCK
State: NM
ZIP Code: 87420 Country: USA
Position and Department: MEDICAL OFFICER OB/GYN % Clinical: 100 % Administrative:
Employment ☑ Staff Privileges ☑ Affiliation ☑ Other:

Applicant Name: CATHERINE CANSINO Date: 2/10/10

State Medical Board of Ohio

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

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:

Name of Hospital/Training Program _____ City _____ Start Date: ____/____ month/year

Specialty Boards

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

Test of Spoken English

(International Medical School Graduates only)

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

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 40 (230 if taken prior to 7/95) on the Educational Testing Services Test of Spoken English (TSE), regardless of citizenship or country of birth, unless you meet one of the following:

	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 required by ECFMG on or after July 1, 1998?	☐	☐

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

OK 2/25/2010 KR

Ohio Addendum to Application

Preliminary Education Form

TO BE COMPLETED BY ALL APPLICANTS

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	CANSINO	CATHERINE	DIANE	

High School or Equivalent

School Name: SOUTH POINT HIGH SCHOOL
City: SOUTH POINT State: OH Country: USA
Dates Attended From: MO/YR 9/92 To: MO/YR 5/94

Undergraduate College or Equivalent

School Name: OHIO STATE UNIVERSITY
City: COLUMBUS State: OH Country: USA
Dates Attended From: MO/YR 9/94 To: MO/YR 6/98 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 TOLEDO
City: TOLEDO State: OH Country: USA
Dates Attended From: MO/YR 8/98 To: MO/YR 6/02 Degree Received: MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 118120 DATE ISSUED: FEB 26 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

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? If yes, complete the Malpractice Liability Claims Information (Form 2). 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 prescriber's 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

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

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. **This form must be notarized by the recommending physician**. 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, CURTIS BOYD, M.D. (recommending physician, print name legibly), a licensed and practicing physician in the state of N. MEX. (state of residence),

affirm that CATHERINE CANSINO (applicant, print name legibly) has been known to me personally for 1 1/2 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: superior
- 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: Highly recommend. Very competent doctor.

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: 522 LOMAS N.E. 87102 City: Albuquerque State: N. Mex Zip Code	Telephone Number (include area code)	505-242-9592
Signature of Recommending Physician (name stamps not acceptable)	Boyd, M.D.	State of Licensure & License Number	N. MEX. & TEX 7111

Signature of Applicant

Date Photo Taken: 2/2010 (month/year)

Subscribed and sworn to before me this 11th day of February, 2010.

Mary P Hagan
Notary Public Signature

3-9-2013
Date Commission Expires

NOTARY SEAL
OFFICIAL SEAL
MARY P HAGAN
NOTARY PUBLIC-STATE OF NEW MEXICO
My commission expires 3-9-2013

State Medical Board of Ohio

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

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. **This form must be notarized by the recommending physician**. 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, Emily Rothman D.O., a licensed and practicing physician in the state of NM,
(recommending physician, print name legibly) (state of residence)

affirm that CATHERINE CANSINO has been known to me personally for 1 1/2 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: Good
- His/her relationship with patients is: Good
- I rate his/her ability to work well with peers and medical staff as: good
- His/her command of the English language is: good
- 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: 522 Lomas Blvd NE City: Albuquerque State: NM Zip Code: 87102	Telephone Number (include area code)	505-242-7512
Signature of Recommending Physician (name stamps not acceptable)		State of Licensure & License Number	NM A-1176-01

Signature of Applicant

Date Photo Taken: 2/2010
month/year

Subscribed and sworn to before me this 5th day of March, 2010.

Notary Public Signature

6/30/12
Date Commission Expires

MEDICAL BOARD
MAR 11 2010

NOTARY SEAL
OFFICIAL SEAL
JOSE LUIS HERNANDEZ
Notary Public
State of New Mexico
My Comm. Expires 6-30-12

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 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 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 licensure or permit to practice medicine.

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

CANSINO
Applicant's Printed Last Name

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

2/10/10
Date of Signature

NOTARY

Dated 02·10·10 Signed Jenelle Casias

State of New Mexico County of Bernalillo

SUBSCRIBED AND SWORN TO before me this 10th day of February 20 10.

My commission expires: 11·12·2012

OFFICIAL SEAL
JENELLE CASIAS
NOTARY PUBLIC - STATE OF NEW MEXICO (NOTARY PUBLIC SEAL)
My commission expires: 11·12·2012

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

PAT QUINN
Governor

BRENT E. ADAMS
Secretary

DANIEL E. BLUTHARDT
Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

March 1, 2010

STATE MEDICAL BOARD OF OHIO
30 E BROAD STREET 3RD FL
COLUMBUS, OHIO 43215-6127

Licensee:	CATHERINE D CANSINO
License Number:	036.120284
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	03/06/2008
Expiration Date:	07/31/2008
License Status:	NOT RENEWED
License Method:	ENDORSEMENT - USMLE
Disciplinary History:	Has not been disciplined

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.

Daniel E. Bluthardt
Director
Division of Professional Regulation

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

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

MEDICAL BOARD
MAR 04 2010

Please contact the *Division of Professional Regulation, Licensure Maintenance Unit,* at 217-782-0458 if you have any questions.

State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation
320 W. Washington St., 3rd Floor, Springfield, IL 62786

ATTENTION

The attached document is an official
State of Illinois
Licensure certification/verification, prepared by the
Illinois Department of Financial and Professional Regulation.

This certifies that the named individual has met all of the education/examination requirements by law in order to receive the credential that is being verified.

The Department has eliminated specific examination status from certifications/verifications of licensure, as passage of an examination is a requirement for licensure.

This information is the **ONLY** certification information provided by this Department. If other information is needed, it **MUST** be obtained from the applicant.

THANK YOU

Form #1

Licensure Verification Form
(Copy this form for multiple licenses)

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH ST, 17TH FLOOR
COLUMBUS, OH 43215 - 6127

To be completed by applicant

Applicant Name: CANSINO (Last) CATHERINE (First) DIANE (Middle) (Suffix)

Date of Birth: 1/18/1978 Social Security Number: REDACTED License Number: 036 120284
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of ILLINOIS to furnish the information to the Board indicated below.

Signature of Applicant [signature] Date 2/10/10

Board Name: ILLINOIS DEPT OF FINANCIAL & PROFESSIONAL REGULATION

Address: 320 W. WASHINGTON ST, 3RD FLR (Street) SPRINGFIELD (City) IL (State) 62786 (ZIP Code)

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: (Last) (First) (Middle) (Suffix)

License Type: License #: Issue Date: Expiration Date:

Is this license current? ☐Yes ☐No If No, please explain:

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain:

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended, or in any other manner, limited by a licensing or disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain:

RECEIVED
BUSINESS SERVICES
FEB 16 2010
IDFPR
Div of Professional Regulation

Affix Board Seal Here

Board Authorized Signature:

Title:

Date:

Please return this form to the Board listed at the top of this form.

Applicant Name: Date:

MEDICAL BOARD
MAR 04 2010

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
4201 Patterson Avenue
Baltimore, MD 21215-0095
(410) 764-4777
Fax (410) 358-2252

February 24, 2010

Requested by: Medical Board of Ohio

The following is available under the Maryland Public Information Act, State Government Article, Section 10-617(h), regarding the following practitioner:

CANSINO, CATHERINE DIANE
3793 CANDELARIAS LANE NW
ALBUQUERQUE, NM 87107

License Number: D0064402

Date Issued: April 19, 2006

Current Status: Active

Expiration Date: September 30, 2010

Medical School: MED COLL OF OHIO, TOLEDO

Licensed By: USMLE Steps 1, 2, and 3

Specialty:

Charges:

Disciplinary Actions: NONE

No Maryland Health Claims Arbitration Office malpractice claims filed since July 1, 1986

Suzanne Cox

Verification Clerk

02/24/2010

Date

This is a computer generated form which is acceptable by other states.
Licensing examination scores should be requested directly from the examining authority.

4635

50 C.N. 96656

Form #1

Licensure Verification Form
(Copy this form for multiple licenses)

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH ST, 17TH FLOOR
COLUMBUS, OH 43215 PHONE 443 465 9340 CONTACT OF APPLICANT

To be completed by applicant

Applicant Name: CANSINO (Last) CATHERINE (First) DIANE (Middle) (Suffix)

Date of Birth: 1/18/1978 Social Security Number: REDACTED License Number: D0064402
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of MARYLAND to furnish the information to the Board indicated below.

Signature of Applicant [signature] Date 2/10/10

Board Name: MARYLAND BOARD OF PHYSICIANS

Address: PO BOX 37217 (Street) BALTIMORE (City) MD (State) (ZIP Code)

MEDICAL BOARD
MAR 02 2010

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: (Last) (First) (Middle) (Suffix)

License Type: License #: Issue Date: Expiration Date:

Is this license current? ☐Yes ☐No If No, please explain:

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain:

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended, or in any other manner, limited by a licensing or disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain:

Affix Board Seal Here

Board Authorized Signature:

Title:

Date:

Please return this form to the Board listed at the top of this form.

Applicant Name: CATHERINE CANSINO Date: 2/10/10

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

LICENSE VERIFICATION

February 10, 2010

This is to certify that the records of the New Mexico Medical Board indicate the following information regarding the below mentioned physician.

Name: Catherine Diane Cansino, M.D.

Date of Birth: 01/18/1978

School Name	Graduation Date
University of Toledo COM	06/01/2002

Specialties

Obstetrics and Gynecology

License #	Issue Date	Expiration Date	Status	License Type
MD2008-0671	08/18/2008	07/01/2012	Active	Medical Doctor

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

This license information was last updated on: 02/10/2010

Lynn S. Hart

Lynn S. Hart, Executive Director

Date: February 10, 2010

URGENT LICENSURE PENDING

State Medical Board of Ohio

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

3/31/2010

Northern Navajo Medical Center
Director, Dept. of Medical Officers
P O Box 160 Highway 491 N
Shiprock, NM 87420

Dear Doctor:

Dr. Catherine Diane Cansino who is/was Medical Officer, October 10/09 to present is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. To ensure processing of the physicians application please complete and return this form to the State Medical Board of Ohio by mail within two (2) weeks. Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

(1) How long have you known him/her? 8 months

(2) What is/was your supervisory capacity? None for the last 4 months + now I am the Chief of the dept.

(3) At what hospital? NNMC

(4) How would you rate his/her medical knowledge and techniques? excellent

(5) In your opinion is he/she a person of good moral and ethical character? definitely

(6) Does he/she work well with peers and medical staff? yes

(7) Does he/she relate well to patients? yes

(8) How is his/her command of the English language if applicable)? excellent

(9) Would you recommend him/her for licensure? yes

Additional comments, please: (f needed, an extra sheet of paper may be used)

I have no reservations.

Sincerely,

Penny E. Grubb
Chief, Licensure

Wilder

Signature of Physician

Kathleen Wilder MD, MHS

Name of Physician (please type or print clearly)

Chief, OB/Gyn

Position

505-368-7060

Telephone number (include area code)

505-368-7011

FAX number (include area code)

MEDICAL BOARD
APR 23 2010

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 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 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.

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

CANSINO
Applicant's Printed Last Name

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

2/10/10
Date of Signature

NOTARY

Dated 02.10.10 Signed

State of New Mexico County of Bernalillo

SUBSCRIBED AND SWORN TO before me this 10th day of February 20 10.

My commission expires: 11.12.2012

OFFICIAL SEAL
JENELLE CASIAS
NOTARY PUBLIC - STATE OF NEW MEXICO (NOTARY PUBLIC SEAL)
My commission expires: 11-12-2012

NORTHERN NAVAJO MEDICAL CENTER

MEDICAL STAFF MANAGEMENT DEPARTMENT
US HWY 491 North / PO Box 160
Shiprock, NM 87420
Fax: 505-368-7011

FACSIMILE TRANSMITTAL SHEET

RECIPIENT'S NAME: STATE MEDICAL BOARD OF OH

FROM: Dr. Kathleen Wilder

COMPANY:

SENDER'S TELEPHONE NUMBER: (505) 368 7060

FAX NUMBER: 614 728 5946

TOTAL NUMBER OF PAGES INCLUDING COVER: 3

TELEPHONE NUMBER: 614 466 3934

SEND DATE and TIME: 4/23/10 240 MDT

RE: PEER EVALUATION FORM FOR DR. CATHERINE CANSINO

☒ URGENT ○ Please Process ○ As requested ○ FYI

NOTES/COMMENTS: (NEW MEDICAL LICENSE APPLICANT)

35-095223

URGENT LICENSURE PENDING

State Medical Board of Ohio

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

5/5/10

3/31/2010

Northern Navajo Medical Center
Director, Dept. of Medical Officers
P O Box 160 Highway 491 N
Shiprock, NM 87420

Dear Doctor:

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(7) Does he/she relate well to patients? yes

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(9) Would you recommend him/her for licensure? yes

Additional comments, please: (f needed, an extra sheet of paper may be used)

I have no reservations.

Sincerely,

Penny E. Grubb
Chief, Licensure

Wilder

Signature of Physician

Kathleen Wilder MD, MHS

Name of Physician (please type or print clearly)

Chief, OB/Gyn

Position

505-368-7060

Telephone number (include area code)

505-368-7011

FAX number (include area code)

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.

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And
Authorization For Release of Information

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RECEIVED
MAY 03 2010
MEDICAL BOARD

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.

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

CANSINO
Applicant's Printed Last Name

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

2/10/10
Date of Signature

NOTARY

Dated 02.10.10 Signed

State of New Mexico County of Bernalillo

SUBSCRIBED AND SWORN TO before me this 10th day of February 20 10.

My commission expires: 11.12.2012

OFFICIAL SEAL
JENELLE CASIAS
NOTARY PUBLIC - STATE OF NEW MEXICO (NOTARY PUBLIC SEAL)
My commission expires: 11.12.2012

Applicant Name: CATHERINE CANSINO Date: 2/10/10

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:	**Catherine Diane Cansino**
SSN:	REDACTED
DOB:	**01/18/1978**
Packet ID:	**91748**
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.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Catherine Diane Cansino**	
Other Name Used:	**N/A**	
Gender:	**Female**	
Date of Birth:	**01/18/1978**	
Place of Birth:	**Philadelphia County, PA USA**	
SSN:	REDACTE	
Current Address:	**3793 Candelarias Lane Northwest** **Albuquerque, NM 87107**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**N/A**
	Fax:	**N/A**
	Home:	**443-465-9340**
	Other:	**N/A**
Physical Description:	Height:	**5' 04"**
	Weight:	**122 lbs**
	Eye Color:	**Black**
	Hair Color:	**Black**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

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

Institution:	**Ohio State University, Columbus, OH 43210-1233**
Dates of Attendance:	**09/1994 - 06/1998**
Degree Conferred/Issued:	**Bachelor of Science**

Medical Education:

Medical School:	**University of Toledo College of Medicine** **Health Science Campus** **3045 Arlington Avenue Rm 114** **Toledo, OH 43614-5805**
Dates of Attendance:	**08/24/1998 - 06/07/2002**
Date Degree Conferred/Issued:	**06/07/2002**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Graduate Medical Education:

Institution:	**Johns Hopkins Hospital** **Department of Obstetrics and Gynecology** **600 North Wolfe Street Phipps 279** **Baltimore, MD 21287**
Training Level:	**1**
Program Type:	**Internship**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2002 - 06/30/2003**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**2-4**
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2003 - 06/30/2006**
Completion:	**Yes**
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:	Catherine Diane Cansino
DOB:	01/18/1978
SSN:	REDACTED
Packet ID:	91748
Request ID:	21803453

OMISSIONS

Omission 1:

Section of Profile: **Medical Education**

Omission: Un of Toledo responded only to the Interruption/Extension and Probation Question(s) in the Unusual Circumstances section of the Medical Education form.

Follow-Up: See comments on Verification of Medical Education Form. A copy of the FCVS Medical Education application page completed by the applicant is included.

DISCREPANCIES

Discrepancy 1:

Section of Profile: **Examination History**

Discrepancy: The applicant reports sitting for USMLE Step 2 in 11/2001. The USMLE transcript report(s) the examination date was 10/25/2001.

Follow-Up: Left to Recipient`s discretion.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile: **Post-Graduate Education**

Issue: The applicant and Johns Hopkins Hospital do not report the same program types for PGY 1.

Follow-Up: FCVS does not follow up on program type based on the definition of a resident per ACGME (A physician at any level of GME in a program accredited by the ACGME is considered a resident.)

End of report for Catherine Diane Cansino

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name	**Cansino, Catherine Diane**
Date of Birth:	**01/18/1978**
Medical School:	**036030 - University of Toledo College of Medicine**
Year of Graduation:	**2002**
Social Security Number:	REDACTED
ECFMG Number:	**N/A**

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

FEB 09 2010

Humayun J. Chaudhry, D.O., FACP
President and CEO

FSMB

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 2/9/2010

State Queried For: State Medical Board of Ohio

Physician Name: Catherine Diane Cansino

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.

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.

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

Cansino
Applicant's Printed Last Name

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

5/27/08
Date of Signature

1/18/1978
Date of Birth

REDACTED
Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of Maryland County of Baltimore

SUBSCRIBED AND SWORN TO before me this 27 day of May, 20 08

My commission expires: 11/1/08

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: Ricka C. Sherman

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: 01-18-1978

FILE NO: 0089200-1978

DATE FILED: 01-26-1978

COUNTY OF BIRTH: PHILADELPHIA

DATE ISSUED: 05-21-2008

NAME
CATHERINE DIANE CANSINO

SEX FEMALE

FATHERS NAME
SILVESTRE P CANSINO

MOTHERS MAIDEN NAME
DOROTEA Y JIMENEZ

SEAL VERIFIED

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 Act 66, P.L. 304, approved by the General Assembly, June 29, 1953.

Calvin B. Johnson, M.D., M.P.H.
Secretary of Health

HTCS.105 Rev.8/06

Frank Yeropoli
State Registrar

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

ULC

14620220

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 Toledo College of Medicine

Complete Address: 3000 Arlington Ave MS1041

Street Address: Health Science Campus

City: Toledo **State:** OH **ZIP Code (Postal Code):** 43614

If name of institution was different when this individual attended, please note this name below: MEDICAL UNIVERSITY OF OHIO AT TOLEDO

MEDICAL COLLEGE OF OHIO

Premedical Education:

Years of education required for admission to your medical school: 4yr under grad

Credential/degree presented by the applicant for admission to your medical school: BS

Enrollment and Participation: Our records indicate that Cansino Catherine Diane
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 120 weeks of medical education on the following dates (mm/dd/yy):

From 8 / 24 / 1998 (Month / Date / Year) **To** 6 / 7 / 2002 (Month / Date / Year)

This individual (check one):

Was awarded the degree of MD on 6 / 7 / 2002 (Month / Date / Year)

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

Certification: By my signature, I, Diane M Pfaff (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.

SEAL VERIFIED

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

Signature: Diane McPfaff

Title: Education Coordinator

Date of Signature: 6/20/2008

Phone: (419) 383 3600 **Fax:** (419) 383 4003

Email: HSCRegistrar@UTOLEDO.EDU

GWM

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)
(continued)

VERIFICATION OF MEDICAL EDUCATION

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):

   _____

   THE REGISTRAR'S OFFICE IS RESPONSIBLE FOR ACADEMIC DEGREE VERIFICATION ONLY

4. Do this individual's official records reflect that he/she was ever the subject of negative reports, actions, or findings 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):

   _____

   THE REGISTRAR'S OFFICE IS RESPONSIBLE FOR ACADEMIC DEGREE VERIFICATION ONLY

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.

   _____

   THE REGISTRAR'S OFFICE IS RESPONSIBLE FOR ACADEMIC DEGREE VERIFICATION ONLY

Medical Education

School	036030 - University of Toledo College of Medicine
Dates	08/1998 to 06/2002
Clinical Training	*No information reported.*
Grad Date	06/07/2002
Degree	MD

Completed clinical clerkship in a country other than where my medical school was located: N

Unusual Circumstances:

Interruptions: N

Probation: N

Disciplined: N

Negative Reports: N

Limitations: N

Attended a Fifth Pathway Program: N

Medical College of Ohio

Office of the Dean

419-383-4000

3045 Arlington Avenue
Mulford Library Building
Toledo, Ohio 43614-5805

419-383-4242

November 1, 2001

Dear Program Director:

As Executive Vice President/Provost and Dean of the School of Medicine at the Medical College of Ohio (MCO), it is a pleasure to provide this Dean's Letter of Evaluation for Ms. Catherine Diane Cansino.

INTRODUCTION

Ms. Cansino graduated summa cum laude with Honors in the Liberal Arts from The Ohio State University (OSU), Columbus, Ohio in June 1998, with a B. S. degree in Psychology and a minor in Spanish. Besides being on the Dean's List for the majority of her undergraduate career, Catherine's other academic achievements included membership in the Phi Beta Kappa Honor Society, Phi Kappa Phi Honor Society, Golden Key National Honor Society, and Phi Eta Sigma Freshman Honorary. In addition, she was a recipient of the Excellence in Scholarship Award, the Summa Award, the Alumni Scholarship, and the OSU Minority Scholars Program Prestigious Scholarship which provided 4-year tuition and a minimal amount of annual stipend. During her undergraduate years, Catherine was highly involved in peer education through the OSU Student Wellness Center. She was also an active community servant, volunteering at Planned Parenthood of Central Ohio/Central Ohio Women's Clinic as a health care assistant and at the Columbus Health Department as an HIV testing counselor.

Ms. Cansino matriculated in the School of Medicine at the Medical College of Ohio (MCO) in the fall of 1998. During medical school, she has continued to demonstrate her commitment to volunteer work and community service by being involved with Center for Choice and Hospice of Northwest Ohio. She has also participated in several international medical/surgical missions to El Salvador, Honduras, and the Philippines. In addition, Catherine has distinguished herself as an active student leader on our campus. She served as the Activities/Projects Coordinator of the MCO Chapter of the American Medical Women's Association, and was elected as the First Year Representative for the Students for Medical Missions organization.

PRECLINICAL RECORD

Catherine Cansino has performed excellently throughout the preclinical and clinical curriculum at the Medical College of Ohio, as evidenced by her election into Alpha Omega Alpha. In the preclinical curriculum, Catherine received all High Pass and Honors grades in her first year, and Honors in all of her second year classes. She further demonstrated her strong fund of basic science knowledge and her ability to apply that knowledge in clinical problem solving by scoring 227 on the USMLE Step 1. In addition to the required preclinical curriculum, Catherine completed electives in HIV/AIDS and Community Health Issues, as well as a full-time internship in MCO's Community Health Project during the summer after her first year of medical school.

Ms. Cansino's grades in the preclinical courses and required third year clerkships are denoted as asterisks in the enclosed frequency histograms. The histograms provide comparative data with Catherine's peers by plotting the percent of students who earned grades of Fail, Defer, Pass, High Pass, or Honors, respectively, in each course or clerkship. A brief description of the integrated preclinical curriculum at MCO is also enclosed with this letter.

CLINICAL CLERKSHIP RECORD (In chronological order)

Surgery: Ms. Cansino received a final grade of Honors in the Surgery clerkship, and scored in the 74th percentile nationally on the National Board of Medical Examiners (NBME) subject exam. She also passed the Surgery OSCE and scored above the average of her peers on her two oral examinations. During this three-month clerkship, Catherine successfully finished month-long rotations in Neurosurgery, General Surgery, and Vascular Surgery. Catherine completed the subspecialty rotations at MCO, and the General Surgery rotation in rural Lima, OH where she was able to have more hands-on experience in the operating room as a first assistant

during surgical procedures. The Neurosurgery team rated Catherine's overall clinical performance at the Honors level. The resident on the service stated, "Catherine is an outstanding student. She was a pleasure having on service. For her first rotation, I was extremely impressed with her medical knowledge and comfort in a patient care setting. A good team player. She is well deserving of Honors for this rotation." Catherine's community preceptor in General Surgery stated that Catherine was a "Good student. Well prepared for cases. Good knowledge base." The Chief of Vascular Surgery rated Catherine's overall clinical performance at the Honors level. He indicated that Ms. Cansino was an enthusiastic, exceptionally hard working student, who maintained an outstanding standard of professional behavior and established exceptional rapport with her patients.

Psychiatry: Catherine earned a final grade of Honors in Psychiatry, and scored in the 78th percentile nationally on her NBME subject exam. She completed six weeks of inpatient psychiatry consisting of three weeks in Child Psychiatry at MCO's Child Inpatient Unit and three weeks in Adult Psychiatry at the state psychiatric hospital. Her attending on the child psychiatry service rated Catherine's overall clinical performance at the High Pass level, and commented that she "demonstrates competence and interest, related well with children, and responded well to feedback." He also stated that her written clinical case evaluations were "comprehensive and very good." Catherine earned Honors for her clinical performance on the adult psychiatry rotation. Her attending stated that Catherine had an "excellent knowledge base. Very quick on the progress notes. Displayed a good understanding of psychiatric problems."

Obstetrics and Gynecology: In her chosen specialty, Catherine scored in the top quartile of the nation on the NBME subject exam, and received a final grade of High Pass. She completed the entire six-week clerkship in Obstetrics & Gynecology at Riverside Methodist Hospital in Columbus, OH, an educational affiliate of MCO. Catherine spent two weeks each in Labor & Delivery and Benign Gynecology and one week each in Gynecological Oncology and High-Risk Obstetrics. In the composite clinical evaluation, her evaluators indicated that Catherine's H&Ps and progress notes were very good, that her diagnostic and therapeutic program planning reflected current standards of practice, and that she was able to relate basic medical principles to patient problems. They also noted that Catherine was an active member of the team who works well with other members.

Internal Medicine: Ms. Cansino received a final grade of High Pass in Internal Medicine based on her excellent clinical performance and her passing score on the NBME subject examination. Catherine completed three four-week rotations in Internal Medicine, earning a majority of Honors evaluations for her clinical performance throughout the twelve-week clerkship. During her first month, Catherine was assigned to an inpatient General Internal Medicine service. The intern on the service rated Catherine's overall clinical performance at the Honors level and stated, "Excellent student. Always contributed on rounds and knew patients well. Will make excellent resident in whatever field she chooses. A pleasure to work with. Great rapport with patients." Ms. Cansino spent the next two weeks doing Palliative Care at Hospice of Northwest Ohio. The Medical Director of Hospice, the Chairman of Anesthesiology at MCO and a pain management specialist, rated Catherine's overall clinical performance at the High Pass level, and stated, "Cat did a great job. She was well informed, attentive, and appropriate with her patients. She demonstrated a sound knowledge base and good communication skills." The last two weeks of her second rotation were spent on the inpatient medicine subspecialty service. During this time, Catherine saw a variety of cases in a number of specialty areas, including Hematology/Oncology, Infectious Diseases, Gastroenterology, Dermatology, and Rheumatology. All of her attendings and residents rated Catherine's overall clinical performance as Honors. Representative comments included: "Catherine did an outstanding job. She is very hardworking and always kept up on her work. Very precise notes and H&Ps. Patient and health care rapport was exceptional." "Excellent understanding of problems and therapeutic approaches. Professional, efficient, thorough. Has a broad base of medical knowledge." Catherine's last four-week rotation was spent working one-on-one with two internists in their private practice. Catherine had the unique opportunity of accompanying one of the physicians on a medical mission to La Esperanza, Honduras during the third week of the rotation. Both community preceptors rated Catherine's overall clinical performance at the Honors level. Excerpts of their laudatory comments included: "Excellent student." "Good knowledge base." "Good presenter." "Excellent notes." "Excellent rapport with patients and staff." "Treated 1850 patients in 6 days (in Honduras). Team member who worked well under trying conditions." "Will do well in whichever field of medicine she chooses."

Pediatrics: Catherine scored in the 71st percentile nationally on the NBME subject examination and received a final grade of High Pass in Pediatrics. During this six-week clerkship, Catherine completed two weeks on an inpatient General Pediatrics service and two weeks in the Pediatrics Intensive Care Unit. She also spent two weeks working with a pediatrician in the community. After spending one week in the preceptor's office, Catherine accompanied the physician on a surgical/medical mission to Manaoag, Philippines, where she saw children in the improvised clinics, and also performed circumcisions on pre-pubescent boys. The Clerkship Director, the attending on the General Pediatric inpatient service, gave Catherine the highest possible rating on her history taking skills, describing the history as systematic, comprehensive, thorough, precise, and efficiently done. The attending and residents on the ICU team

indicated that Catherine demonstrated medical knowledge beyond her level of training, and also noted that her differential diagnoses were consistently accurate, logically derived and complete.

Family Medicine: Catherine earned a final grade of Honors in Family Medicine, including Honors for her clinical performance throughout the six-week clerkship, Honors on her oral debriefing assessment, and an Honors level score (79th percentile nationally) on the NBME subject examination. Catherine completed an urban AHEC experience, which focused on inpatient and outpatient care of indigent populations in a central city Family Practice Residency program. During the clerkship, Catherine also spent two weeks at the Toledo Health Department in the Adult Medicine clinic and the STD clinic. Comments from her preceptors included: "She is bright, enthusiastic, and has an excellent fund of knowledge. Would encourage her to enter primary care." "Excellent clinical judgment." "Data handling above average." "Enthusiastic. Punctual. Wrote very good SOAP notes. Was a pleasure to work with. Would do an excellent job in any residency program."

ELECTIVES

Medical Complications in Pregnancy: Ms. Cansino received a final grade of Honors in her clinical clerkship at Baystate Medical Center in Springfield, Massachusetts, a community teaching hospital affiliated with Tufts University School of Medicine. Catherine worked directly with the Department of Maternal-Fetal Medicine, participating in the care of high-risk obstetric patients in both the inpatient and ambulatory care settings. Catherine prepared several presentations, including a case presentation regarding HIV and Pregnancy for the Maternal-Fetal Medicine Teaching Rounds that involved both the Departments of Obstetrics & Gynecology and Pediatrics. After conferring with other faculty members and residents, the clinical preceptor remarked that Catherine "performed extremely well. She made several presentations which were very well reviewed, in depth, and timely. She was immediately a team member and will be a fine resident/house officer."

Obstetrics Sub-Internship: In order to better prepare herself for residency, Ms. Cansino challenged herself with an acting internship in Obstetrics at Magee-Women's Hospital, an affiliate of the University of Pittsburgh School of Medicine. She performed very well in the clerkship and received a final grade of High Pass. During the four-week rotation, Catherine carried out the clinical duties expected of a first-year resident including managing the care of patients during their labor and delivery, assessing obstetric patients in the triage setting, and providing inpatient postpartum care. She also improved her procedural skills, including becoming more proficient in ultrasound use. The Clerkship Director stated, "Catherine performed very well during her OB/GYN rotation elective. She performed at a true intern level, and was very skilled in the area of educating other students. She will be an asset to any residency program."

SUMMARY

Ms. Cansino is one of the best students with whom I have worked. Catherine is diligent, hard working, well read, and always eager to learn more. She is a pleasure to work with, and is very well liked and respected by her peers, the staff, and the faculty. Lucky will be her patients; not only will they be cared for by an excellent doctor, but also a very special person who is truly caring and will always go the extra mile for her patients' comfort and well-being. Catherine is also very sensitive, a good listener, and has the highest ethics. I am proud that she is a part of our MCO family. I am sure that she will be an asset to any program that she joins. Therefore if I can be of any further assistance, please do no hesitate to contact me.

Sincerely,

Amira F. Gohara, M. D.
Executive Vice President and Provost
Dean of the School of Medicine
Professor of Pathology

Enclosures: Preclinical course descriptions
Histograms

Brief Description of the Integrated Preclinical Curriculum at the Medical College of Ohio

In the fall of 1998 the Medical College of Ohio implemented significant revisions for the preclinical portion of the medical school curriculum. These changes included the restructuring of ten departmental courses into six integrated curricular "blocks" and the development of a two-year long integrative Pathophysiology course.

The following is a brief description of the content covered in each of the curricular blocks of preclinical years.

Block 1- Cellular and Molecular Biology (12 weeks)
This block includes integrated topics from the disciplines of Biochemistry, Physiology, Microanatomy, Pharmacology and Pathology. Students are introduced to topics in cell structure and function, the molecular structure of proteins, enzymes and lipids, concepts of cell and tissue injury, molecular genetics, carcinogenesis, mutagenesis and gene alteration and therapy.

Block 2- Human Structure and Development (14 weeks)
In this block regional Gross anatomy serves as a framework for systems Microanatomy and Embryology content. Students accomplish traditional cadaver dissections and histology laboratories. The information presented in lecture and lab is reinforced during small group case-based discussions.

Blocks 3a and 3b – Neuroscience and Behavioral Sciences (9 weeks)
In this block, topics of two courses, Neuroscience and Behavioral Science, are delivered concurrently, but graded independently. Correlation of the content of these two courses gives students the neuroanatomical and neurophysiologic foundation required for a better understanding of the behavioral disorders presented during Behavioral Sciences.

Blocks 4 and 8 - Year 1 and 2 of Integrative Pathophysiology (33 weeks each year)
This block is taught in a student-directed problem-based learning format. Students are presented with case studies that closely parallel areas of content being presented in other courses in the curriculum at the time. Students learn to develop effective clinical reasoning skills by developing hypotheses and explaining the rationale for testing those hypotheses while exploring the pathophysiologic mechanisms of disease.

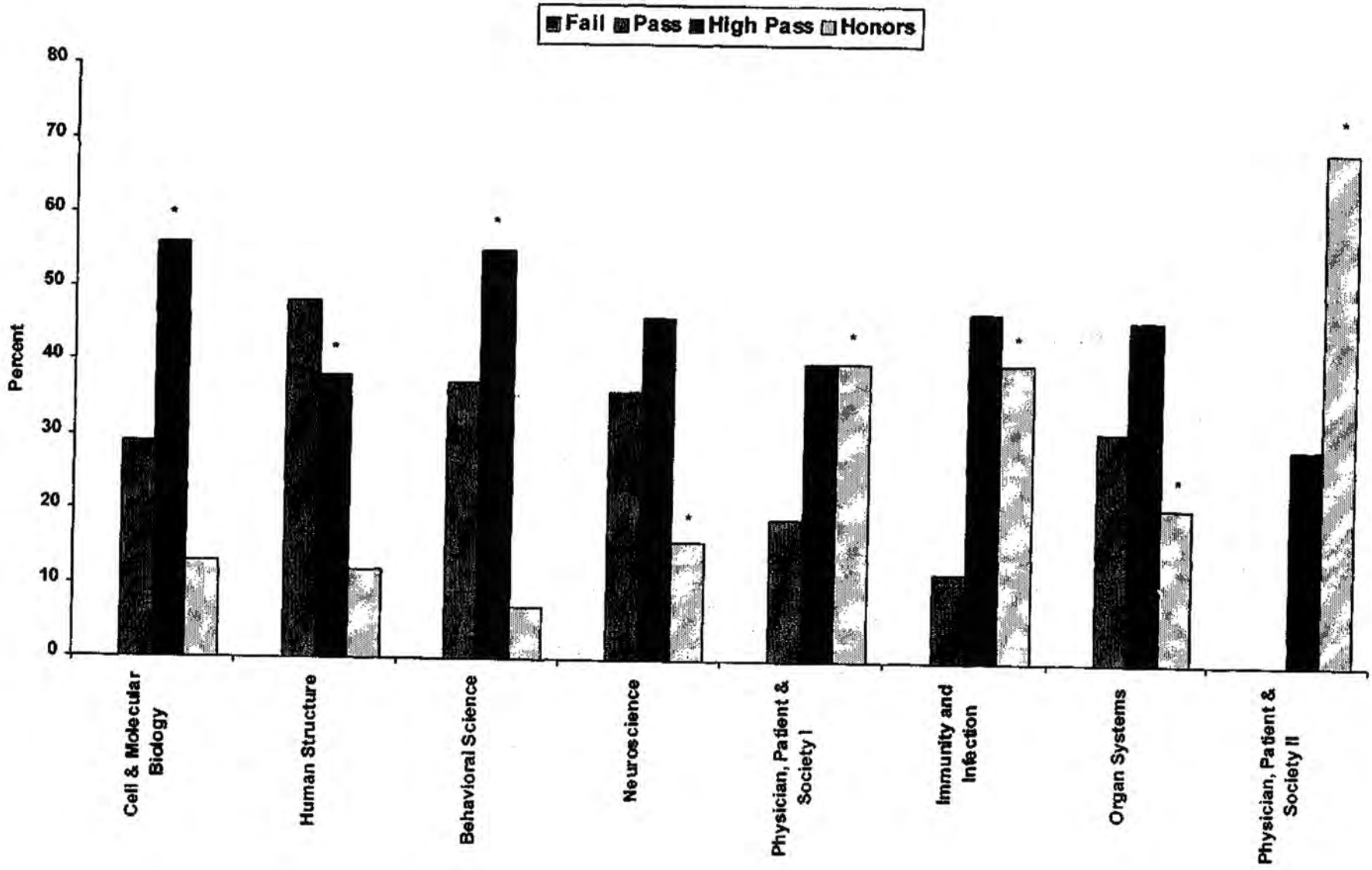
Block 6 – Immunity and Infection (12 weeks)
This block includes integrated topics from Immunology, Bacteriology, Virology, Mycology, Parasitology and Infectious Diseases. The material is taught using a combination of lectures, case study presentations, laboratories, and individual learning activities.

Block 7 - Organ Systems (20 weeks)
This curricular block is organized around nine organ system units (cardiovascular, nervous, respiratory, renal, gastrointestinal, endocrine, reproductive, skin, and skeletal). Within each unit the students are introduced to the relevant physiology, pharmacology and pathology for the system.

Blocks 5 and 8 – Year 1 and 2 of Physician, Patient and Society (33 weeks each year)
The curricular content of this two-year course is integrated with the students' early clinical experience and their introduction to interviewing and physical diagnosis skills. Lecture topics include; medical ethics and humanities, managed care issues epidemiology, statistics, clinical outcomes and substance use disorders.

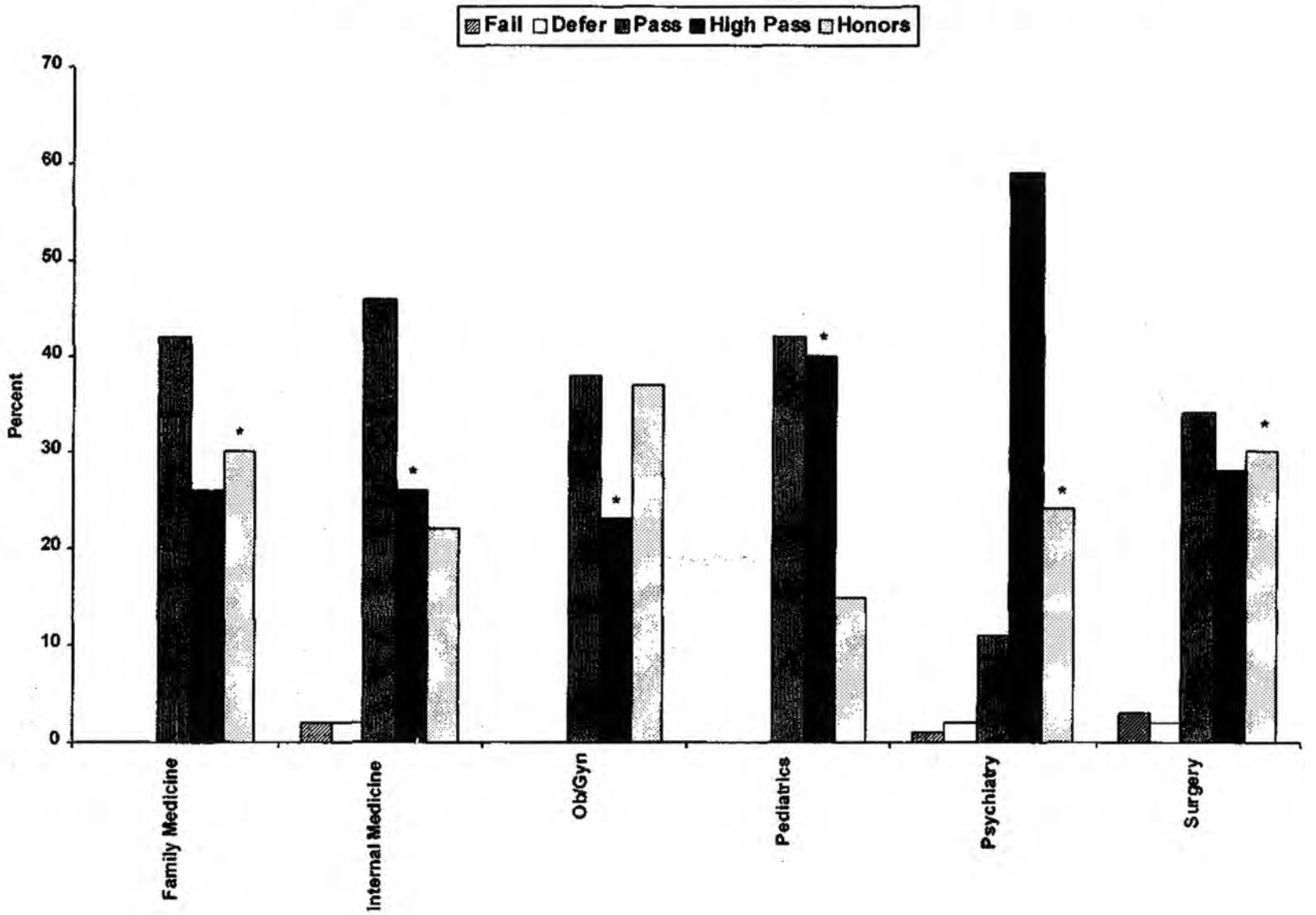
Class of 2002 Grade Distribut Histogram of Basic Sciences
For
Catherine Cansino

This Histogram shows the percentage of students who received a grade of Fail, Pass, High Pass, or Honors, respectively for each class. The asterisk (*) indicates the individual student's grade for the



Class of 2002 Grade Distribution His ,ram of Required Clinical Clerkships
For
Catherine Cansino

This Histogram shows the percentage of students who received a grade of Fail, Pass, High Pass, or Honors, respectively for each class. The asterisk (*) indicates the individual student's grade for the



The [redacted]versity of Toledo Health Science Ca[redacted]us
(formerly Medical College of Ohio at Toledo)
3045 Arlington Avenue, Toledo, OH 43614-5805

Academic Transcript

Name: Catherine Diane Cansino
Student ID: 1127
Entry Date: 08/24/1998

Create Date: 06/17/2008

Programs of Study	Date Matriculated	Date Awarded	Concentration Or Major	Track
Doctor of Medicine	08/24/1998	06/07/2002		

College of Medicine Record

**** Academic Year 1998 - 1999 ****

Course #	Course Title	Course Credit	Final Grade
INDI775	Cellular & Molecular Biology 08/24/1998 - 11/13/1998	15.00	HP
SOMN600	Basic Life Support 08/24/1998 - 12/18/1998	1.00	S
INDI776	Physician, Patient & Society I 08/24/1998 - 05/07/1999	5.00	H
INDI777	Integrative Pathophysiology I 08/24/1998 - 05/07/1999	8.00	S
ANAT679	Human Structure 11/16/1998 - 02/26/1999	14.00	HP
SOMN683	HIV/AIDS 01/11/1999 - 05/07/1999	0.00	CR
SOMN709	Community Health Issues 01/11/1999 - 05/07/1999	0.00	CR
ANAT680	Neuroscience 03/01/1999 - 05/07/1999	6.00	H
PSYC681	Behavioral Science 03/01/1999 - 05/07/1999	4.00	HP

**** Academic Year 1999 - 2000 ****

Course #	Course Title	Course Credit	Final Grade
INDI783	Immunity and Infection 08/23/1999 - 11/24/1999	14.00	H
SOMN709	Community Health Issues 08/23/1999 - 12/17/1999	0.00	CR
INDI781	Integrative Pathophysiology II 08/23/1999 - 05/12/2000	8.00	S
INDI782	Physician, Patient & Society II 08/23/1999 - 05/12/2000	8.00	H
INDI780	Organ Systems 11/29/1999 - 05/08/2000	24.00	H
SOMN603	Adv Cardiac Life Support 03/13/2000 - 04/14/2000	1.00	S

**** Academic Year 2000 - 2001 ****

Course #	Course Title	Course Credit	Final Grade
SURG703	Surgery 07/05/2000 - 09/22/2000	18.00	H
PSYC701	Psychiatry 09/25/2000 - 11/03/2000	9.00	H
OBGY701	Obstetrics/Gynecology 11/06/2000 - 12/15/2000	9.00	HP
SOMN610	Medical Spanish 01/01/2001 - 05/31/2001	0.00	CR
MEDI703	Medicine 01/02/2001 - 03/23/2001	18.00	HP
PEDS701	Pediatrics 04/02/2001 - 05/11/2001	9.00	HP
FMMD701	Family Medicine 05/14/2001 - 06/22/2001	9.00	H

**** Academic Year 2001 - 2002 ****

Course #	Course Title	Course Credit	Final Grade
OBGY750	Med Complications in Pregnancy 07/09/2001 - 08/03/2001	6.00	H
OBGY750	Subinternship in OBGYN 08/06/2001 - 08/31/2001	6.00	HP
MEDI704	Medicine Acting Internship 09/03/2001 - 09/28/2001	6.00	H
PATH789	Independent Study in Pathology 10/01/2001 - 10/26/2001	6.00	H
NEUR701	Neurology:Adult 10/29/2001 - 11/23/2001	6.00	HP
MEDI705	Cardiology 11/26/2001 - 12/21/2001	6.00	H
SURG715	Emergency Medicine 01/07/2002 - 02/01/2002	6.00	H
MEDI706	Dermatology 02/04/2002 - 03/01/2002	6.00	P
MEDI714	Infectious Disease Medicine 03/04/2002 - 03/29/2002	6.00	HP
ANAT711	Clinical Anatomy 04/08/2002 - 04/19/2002	3.00	P
FMMD755	International Health 04/22/2002 - 05/03/2002	3.00	H
FREE001	Free Time 05/06/2002 - 05/31/2002	0.00	

SEAL VERI

Sher... Director of Student Services and Registrar

The University of Toledo Health Science Campus
(formerly Medical College of Ohio at Toledo)
3045 Arlington Avenue, Toledo, OH 43614-5805

Academic Transcript

Name: Catherine Diane Cansino
Student ID: 1127
Entry Date: 08/24/1998
Create Date:06/17/2008

Programs of Study	Date Matriculated	Date Awarded	Concentration Or Major	Track
Doctor of Medicine	08/24/1998	06/07/2002		

Course #	Course Title	Course Credit	Final Grade	Course #	Course Title	Course Credit	Final Grade

End of College of Medicine Record

College of Graduate Studies Record

******* Summer 1999 *******

INDI507	Community Health Project	4.00		S

	Earned Hrs	Qual Hrs	Qual Pts	GPA
Semester	4.00	0.00	0.00	0.00
Cumulative	4.00	0.00	0.00	0.00

End of College of Graduate Studies Record

SEAL VERIFIED

Sherri Armstrong, Director of Student Services and Registrar

A raised seal is not required. When photocopied a security statement containing the institution name will appear. A BLACK ON WHITE OR COLOR COPY SHOULD NOT BE ACCEPTED!

TO VERIFY: TRANSLUCENT GLOBE ICONS MUST BE VISIBLE WHEN HELD TOWARD A LIGHT SOURCE

THE UNIVERSITY OF TOLEDO
3045 Arlington Avenue
Toledo, Ohio 43614

LEGEND FOR ACADEMIC TRANSCRIPT

In accordance with the Family Educational Rights and Privacy Act of 1974, as amended. this transcript is released on the condition that you will not permit any other party to have access to this information without the written consent of the individual, whose academic record is being released.

GRADES FOR SCHOOL OF MEDICINE TRANSCRIPT

H	=	Honors
HP	=	High Pass*
P	=	Pass
DF	=	Defer*
F	=	Fail
I	=	Incomplete
W	=	Withdraw
WP	=	Withdraw Pass
WF	=	Withdraw Fail
S	=	Satisfactory
CR	=	Credit
NC	=	No Credit
AU	=	Audit

*Added in 1987

The following School of Medicine courses are graded on a Satisfactory/Fail basis:

SOMN600	Basic Life Support
INDI601	Advanced Cardiac Life Support
INDI777	Integrative Pathophysiology I
INDI781	Integrative Pathophysiology II

GRADES FOR GRADUATE SCHOOL TRANSCRIPT

Grades Affecting the Grade Point Average

A	=	4.00
B	=	3.00
C	=	2.00
D	=	1.00
F	=	0.00
WF	=	0.00

Grades Not Affecting the Grade Point Average

S	=	Satisfactory
U	=	Unsatisfactory
IP	=	In Progress
I	=	Incomplete
WP	=	Withdraw Pass
AU	=	Audit

The University of Toledo is fully accredited by the North Central Association of Colleges and Schools (NCA). The School of Medicine is accredited by the Liaison Committee for Medical Education. Programs in the Graduate School are accredited by multiple agencies, including the Commission on Collegiate Nursing Education, the Accreditation Council for Occupational Therapy, the Accreditation Committee on Education for the Physician Assistant, the Accreditation Board for Engineering and Technology, the Commission of Accreditation for Physical Therapy Education, and the Council on Education for Public Health.

JUN 27 2008

Medical College of Ohio At Toledo

MEDICAL COLLEGE OF OHIO AT TOLEDO
1964

The Faculty and The Board of Trustees
of the Medical College of Ohio at Toledo
hereby confer the degree of

Doctor of Medicine

upon

Catherine Diane Cansino

Who has complied with all requirements of The School of Medicine of The Medical College of Ohio at Toledo
and is entitled to all the honors, rights, and privileges pertaining thereunto.

In testimony whereof, this degree is conferred, sealed with the seal of
The Medical College of Ohio at Toledo, Ohio,
this Seventh Day of June in the year Two Thousand and Two.

THE MEDICAL UNIVERSITY OF OHIO SEAL
IMPRESSED UPON THIS STATEMENT CERTIFIES
THIS AS A TRUE AND EXACT COPY OF THE
ORIGINAL DOCUMENT.

SEAL
VERIFIED

President

Chairman of the Board of Trustees

Assistant Dean, School of Medicine

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: Johns Hopkins Hospital
Address: Department of Obstetrics and Gynecology
Baltimore, MD 21287

Attention: **Program Director**
Affiliated University: ____

Verification For:

Name: **Cansino, Catherine Diane**

DOB: **01/18/1978**

Individual's Name on Record (If different from above): ____

Program Participation:

Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1
☒Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: Ob/Gyn
From: 07/01/2002 To: 06/30/2003
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐FMRAC ☐None of these

PGY: 2, 3, 4
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: Ob/Gyn
From: 07/01/2003 To: 06/30/2006
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐FMRAC ☐None of these

PGY: ____
☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: ____
From: / / To: / /
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐FMRAC ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐Yes ☒No
2. Was this individual ever placed on probation? ☐Yes ☒No
3. Was this individual ever disciplined or placed under investigation? ☐Yes ☒No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐Yes ☒No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐Yes ☒No

Please explain any "Yes" response from above:

____

____

[redacted]

ELECTRONIC SEAL VERIFIED

[redacted]

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Jessica Bienstock, MD, MPH Signature: Jessica Bienstock, MD, MPH

Title: Residency Program Director Date of Signature: 7/14/2006

Tel: 410-955-8487 Fax: 410-502-6683 E-Mail: jbienst1@jhmi.edu

Rev. 09/07/05 Packet ID: 91748 Request ID: 19434045 ENM IFM CODE[12006]

Federation of
STATE
MEDICAL
BOARDS

PROVIDED BY APPLICANT

Full Name: Catherine Cansino

Packet ID: 91748

20. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. **Use one page per institution.**

IMPORTANT:

Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If your postgraduate year is currently in progress, indicate the EXPECTED completion date in the "To" field.

Report internships, residencies, fellowships and research programs separately.

Use one section per department.

(PGY) - Postgraduate years is also known as postgraduate training level.

If a break of six (6) months or more occurred between any of your postgraduate training activities, please provide a written explanation outlining your activities during this period on the "Explanation of Other Activities" form.

Johns Hopkins Hospital
Complete name of hospital where training was conducted (Do not abbreviate).

Johns Hopkins University
Complete name of affiliated university or college (Do not abbreviate).

600 N Wolfe Street
Address line 1

____
Address line 2

Baltimore — City
MD — State/Province
USA — Country
21287 - ____ — ZIP/Postal Code

PGY: 1-4
- ☐ Internship
- ☒ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

Obstetrics and Gynecology
Specialty/Subspecialty

From: 7 /2002 To: 6 /2006

Successfully Completed? ☒ Yes ☐ No ☐ In Progress

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

____
Specialty/Subspecialty

From: ____ To: ____ / ____

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

____
Specialty/Subspecialty

From: ____ To: ____ / ____

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

____
Specialty/Subspecialty

From: ____ To: ____ / ____

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

Unusual Circumstances (check yes or no):

Did you ever take a leave(s) of absence or break(s) from your medical education?	☐ Yes ☒ No
Were you ever placed on probation?	☐ Yes ☒ No
Were you ever disciplined or placed under investigation?	☐ Yes ☒ No
Were any negative reports for behavioral reasons ever filed against you?	☐ Yes ☒ No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	☐ Yes ☒ No

Please explain any "YES" response from above:

____

Signature: *Catherine Cansino* Date: 1/22/10

By typing my name above, I certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information on this application page truthfully and completely.

Section V

Examination History/Score Transcripts

USMLE
United States Medical Licensing Examination™

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

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 : 01/15/2010

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 91748

Examinee: Cansino, Catherine Diane
Alt Name(s):

Examinee ID#: 5-082-416-8
Date of Birth: 01/18/1978

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
	06/20/2009	Pass	227	179	90	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	10/25/2001	Pass	217	174	86	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
MARYLAND	10/16/2002	Pass	195	182	80	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.

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE

Uniform Application for Physician Licensure

UA Username ccansino **Date Submitted** 2/3/2010
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 Cansino
First Name Catherine Diane
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
[X] **Public Access** [X] **Mailing**
Street PO Box 160
City Shiprock **State/Province** NM **Zip Code** 87420
Telephone 505-368-7060
Fax 505-368-7011
Email
Alternate Phone

Home
[ ] **Public Access** [X] **Mailing**
Street 3793 Candelarias Ln NW
City Albuquerque **State/Province** NM **Zip Code** 87107
Telephone 443-465-9340
Fax
Email ccansino@yahoo.com
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

01/18/1978	Philadelphia	Pennsylvania	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	REDACT	1720039936	Are you a U.S. Citizen?	[X] 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 The University of Toledo College of Medicine
Address 3000 Arlington Avenue
City Toledo
State/Province OH
ZIP Code 43614
Country USA
Attendance Dates **From (mm/yyyy)** 08/1998 **To (mm/yyyy)** 06/2002
Graduation Date 6/7/2002
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** Johns Hopkins Hospital
Hospital Address 600 North Wolfe Street Phipps 279

City Baltimore
State/Province Maryland
ZIP Code 21287
Country USA

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

Department/Specialty Obstetrics and Gynecology

From: 07 /2002 **To:** 06 /2006 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

2 **Hospital Name** Johns Hopkins University School of Medicine
Hospital Address 733 North Broadway

City Baltimore
State/Province Maryland
ZIP Code 21205-2196
Country USA

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

Department/Specialty Not Listed

From: 07 /2006 **To:** 06 /2008 **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 1		06/2000	[X] P	[ ] F	1
USMLE Step 2		11/2001	[X] P	[ ] F	1
USMLE Step 3		10/2002	[X] 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

1	**State/Province** MD	**Type** (MD, DO, etc) MD	**License Number**	D0064402	**Status**	Active	**Issue Date**	4/19/2006
2	**State/Province** IL	**Type** (MD, DO, etc) MD	**License Number**	036120284	**Status**	Inactive	**Issue Date**	3/6/2008
3	**State/Province** NM	**Type** (MD, DO, etc) MD	**License Number**	MD2008-0671	**Status**	Active	**Issue Date**	7/1/2009

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: 2002 To: Month: 06 Year: 2006	**Practice/Employment Name** Johns Hopkins University (or list non-working time as indicated above) **Practice/Employment Address** 600 N. Wolfe Street **City** Baltimore **State/Province** Maryland **ZIP Code** 21287 **Country** USA **Position and Department** HouseStaff-Ob/Gyn **% Clinical** 100 **% Administrative** **Employment** [X] **Staff Privileges** [X] **Affiliation** [X] **Other**

Dates: From/To	Practice/Employment
2 From: Month: 07 Year: 2006 To: Month: 06 Year: 2008	**Practice/Employment Name** Johns Hopkins University (or list non-working time as indicated above) **Practice/Employment Address** 4940 Eastern Avenue **City** Baltimore **State/Province** Maryland **ZIP Code** 21224 **Country** USA **Position and Department** Fellow-Ob/Gyn **% Clinical** 50 **% Administrative** 50 **Employment** [X] **Staff Privileges** [X] **Affiliation** [X] **Other**

Dates: From/To	Practice/Employment
3 From: Month: 07 Year: 2008 To: Month: Year:	**Practice/Employment Name** Jhpiego (or list non-working time as indicated above) **Practice/Employment Address** 1615 Thames Street **City** Baltimore **State/Province** Maryland **ZIP Code** **Country** USA **Position and Department** Sr. Technical Consultant-Reprodu **% Clinical** **% Administrative** 100 **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

Dates: From/To	Practice/Employment
4 From: Month: 10 Year: 2008 To: Month: Year:	**Practice/Employment Name** Curtis Boyd, MD, PC (or list non-working time as indicated above) **Practice/Employment Address** 522 Lomas Blvd. NE **City** Albuquerque **State/Province** New Mexico **ZIP Code** 87102 **Country** USA **Position and Department** **% Clinical** 100**% Administrative** **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

Dates: From/To	Practice/Employment
5 From: Month: 02 Year: 2009 To: Month: 05 Year: 2009	**Practice/Employment Name** Presybterian Medical Group - Ob/Gyn (or list non-working time as indicated above) **Practice/Employment Address** 201 Cedar SE Ste 5600 **City** Albuquerque **State/Province** New Mexico **ZIP Code** 87106 **Country** USA **Position and Department** Contract Physician-Ob/Gyn **% Clinical** 100**% Administrative** **Employment** [X] **Staff Privileges** [X] **Affiliation** [X] **Other**

Dates: From/To	Practice/Employment
6 From: Month: 10 Year: 2009 To: Month: Year:	**Practice/Employment Name** Northern Navajo Medical Center (or list non-working time as indicated above) **Practice/Employment Address** PO Box 160 **City** Shiprock **State/Province** New Mexico **ZIP Code** 87420 **Country** USA **Position and Department** Medical Officer-Ob/Gyn **% Clinical** 100**% Administrative** **Employment** [X] **Staff Privileges** [X] **Affiliation** [X] **Other**

Dates: From/To	Practice/Employment
7 From: Month: 09 Year: 2009 To: Month: 09 Year: 2009	**Practice/Employment Name** Stanford University (or list non-working time as indicated above) **Practice/Employment Address** 300 Pasteur Drive, Rm H301 **City** Stanford **State/Province** California **ZIP Code** 94305 **Country** USA **Position and Department** Consultant-Ob/Gyn **% Clinical** **% Administrative** 100 **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

Dates: From/To	Practice/Employment
8 From: Month: 12 Year: 2009 To: Month: Year:	**Practice/Employment Name** Ipas (or list non-working time as indicated above) **Practice/Employment Address** 300 Market Street, Ste 200 **City** Chapel Hill **State/Province** North Carolina **ZIP Code** 27516 **Country** USA **Position and Department** **% Clinical** **% Administrative** 100 **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:

Date Posted: 10/19/2010 10:44:23 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.

Address Information

CREDENTIAL MAIL ADDRESS	920 N. Hamilton Rd Ste. 200 Gahanna, OH 43230 Franklin County Catherine.Cansino@osumc.edu
MAIN	920 N. Hamilton Rd Ste. 200 Gahanna, OH 43230 Franklin County

License Information

License Number	35.095223
License Name	Catherine Cansino

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . 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 any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . 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 othersimilar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . 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

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 25-29

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 1-4

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 10-14

4. "Education" - preceptor, mentor, etc.

. 5-9

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 1-4

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 25-29

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 1-4

3. Enter the number of hours per week spent in "Emergency Room".

. 1-4

4. Enter the number of hours per week spent in "Urgent Care".

.. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 43230

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. 43210

4. Enter the second county:

. . . . . Franklin

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . YES

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

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.