1/15/87
3703 Ault Park Ave
Cincinnati, Ohio
45208

Ohio State Medical Board
65 S. Front Street
Suite 510
Columbus, Ohio 43266

Dear Sir:

I am an NBME diplomate seeking licensure in the state of Ohio. Could you please send me the necessary forms to apply for licensure and the NBME endorsement request card to the following address

Roslyn Kade MD
3703 Ault Park Ave
Cincinnati Ohio 45208

Thank you
Roslyn Kade

KADE, ROSLYN

'87 JAN 20 P2:11
OHIO STATE MEDICAL BOARD

APP. sent
1/21/87
ejr

1-4
34-10-47
2-6-87
185 ...
87

STATE MEDICAL BOARD OF OHIO

APPLICATION FOR MEDICAL OR OSTEOPATHIC LICENSURE
(ALL RESPONSES MUST BE TYPED)

SECTION 1: Identification Information- Answer All Questions

1. Present Legal Name: KADE (last) ROSLYN (first) GLENORE (middle) ____ maiden (if applicable)

2. Address: 3703 Ault Park Avenue (street & number)
Cincinnati (city) Ohio (state) 45208 (zip code) U.S.A. (country)

Intended place of practice: Cincinnati (city) Ohio (state) Hamilton (county)

Telephone: Business (513) 872-3100 (area code) Home: (513) 321-3137 (area code)

4. Place of Birth: Philadelphia (city) PA (state) U.S.A. (country) Date of Birth: 07 / 19 / 51 (mo. day year)

5. *Sex: Male ( ) Female (X) *Optional: For statistical purposes only.

6. Physical description:
Color of Hair Brown Color of Eyes Brown Height 5'7"
Build Medium Marks None Weight 120 lbs.

87 FEB 4 P2:44

7. Immigration or citizenship status:
Indicate which of the following documents you currently possess:
X U.S. Birth Certificate
____ Certificate of Naturalization
Number ____ Date Issued ____ City/State ____
____ Declaration of Intention (issued by the U.S. District Court)
Number ____ Date Issued ____ City/State ____
____ Alien Registration Receipt Card (issued by Dept. of Immigration & Naturalization)
Number ____ Date Issued ____ City/State ____
____ Approved Petition for Immigrant Visa (issued by Dept. of Immigration & Naturalization)
Number ____ Date Issued ____ City/State ____
____ Other, specify ____

Kade, Roslyn G.

8. List all names other than the name given above that you have used. Also indicate the time period during which you used the names. Be sure to include all names. Failure to do so may result in denial. You must supply the appropriate legal document which authorizes the name change. This may be a court decree or a marriage certificate. Any document in a foreign language must be accompanied by an official, certified translation (original) as outlined in Paragraph (A)(8), Page 1 of General Instructions above.

NOTE: Individuals who retain their maiden name or hyphenate their maiden and married name are requested to be consistent in such usage.

Name	used from: mo./yr.	to	mo./yr.
Roslyn Kade Hollingsworth	12/73	to	12/83

SECTION 2: Educational Background

1. Preliminary Education- Census Blank
You must complete the enclosed census blank in order to apply for your preliminary education number as required by Ohio law.

2. List the names of all medical schools attended, the complete addresses, your date of graduation, and the degree that you received. Give the exact degree that appears on your diploma (M.D., D.O., M.B., B.S., M.B., B.Ch., etc.)

name	address	From: mo/day/yr	To: mo/day/yr	degree
University of Cincinnati College of Medicine	Cincinnati, OH 45267	9/81	6/85 (6-9-85)	M.D.

3. You must submit a copy of your original language diploma whether you are an American or foreign graduate.

If it is not in English, you must supply an original certified official translation of your medical diploma which will be returned to you. The translation must be on letterhead stationery, notarized and bear both the official seal and signature of the notary. The translation should be made by one of the following individuals or institutions:

a) a professor of languages in that language
b) a priest or cleric only in the case of Latin documents
c) a recognized translation service, in the United States, e.g., Berlitz
d) a foreign embassy or consulate authorized to certify translations
e) your medical school of graduation only in the case of your medical diploma

The translator must attest to the translation, sign, and date the translation in the presence of a notary or officer authorized to administer oaths. This translation must be submitted in addition to the notarized photocopy of your diploma in its original language.

4. Standard E.C.F.M.G. Certificate

Graduates of foreign medical schools who were not American citizens prior to entering medical school should possess a valid standard E.C.F.M.G. Certificate if they graduated after 1957. Give the number and date of your certificate if applicable.

Number_____ Date_____

5. Submit a copy of E.C.F.M.G. Certificate, if applicable.

SECTION 3: Postgraduate Training

All applicants are required to complete the chart below indicating the dates and hospitals of all postgraduate training in the U.S. Give the complete address of the hospital where you were employed. Give your position and department in which you served. Account for the percentage of your time spent in clinical and administrative duties. These two numbers should add up to 100 percent.

Date mo/yr-mo/yr	Hospital	Complete Address	Position & Department	% Clin.	% Admin
7/85 - current	University of Cincinnati Hospital	234 Goodman Avenue Cincinnati, OH 45267	Resident Obstetrics & Gynecology	100%	

Total Number of Months in Approved* Training: 18 months
*Approved by LCME, AOA, or in Canada.

SECTION 4: Licensure Information- Answer All Questions

1. a) Are you a diplomate of the National Board of Medical Examiners?
Yes (X) No ( ) If so, specify year 1986
Are you a diplomate of the National Board of Examiners for Osteopathic Physicians and Surgeons?
Yes ( ) No (X) If so, specify year _____
Are you a licentiate of the Medical Council of Canada?
Yes ( ) No (X) If so, specify year _____

b) List all FLEX exams which you have taken. Indicate whether you took all three days (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial).

STATE	DATE (Mo/Yr.)				
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )

c) List all other State Board exams taken. Indicate whether you took a full (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial). Also give the month and year you took the exam.

STATE	DATE (Mo/Yr.)				
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )

2. List ALL states in which you are or have been fully licensed to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number and the date it was issued. If the license is properly renewed, check YES under current. If the license was not renewed, check NO.

State	Date of Issuance	License Number	Current
_____			YES ( ) NO ( )
_____			YES ( ) NO ( )
_____			YES ( ) NO ( )
_____			YES ( ) NO ( )
_____			YES ( ) NO ( )

3. List all foreign countries in which you hold a full right to practice medicine and surgery.

Country	Date Conferred	Is Right Currently Held? (Yes or No)
_____	_____	Yes ( ) No ( )
_____	_____	Yes ( ) No ( )

4. Field of Specialization

List the field in which you have specialized (Family Medicine, Internal Medicine, Surgery, etc.). Indicate if you are Board Certified and the countries in which you are so certified.

Field	Board Certified	Year Certified	Country
_____	YES ( ) NO ( )	_____	_____
_____	YES ( ) NO ( )	_____	_____

SECTION 5: General Information- Answer All Questions

Each of the following questions must be answered with a yes or a no answer. Be sure to read each question carefully. All affirmative answers must be thoroughly explained. Attach a separate sheet of paper if necessary.

1. Has any license entitling you to practice in any foreign country or in any state or territory of the United States been suspended, surrendered, or revoked? YES ( ) NO (X) If so, give:

STATE_____DATE_____CHARGE_____

2. Have you ever been denied licensure or application for licensure in any other state or territory for any reason? YES ( ) NO (x)

If so, specify: _____
State or country Reason Date

3. Have you ever been or are you now addicted to the use of drugs or alcohol? YES ( ) NO (x)

4. Have you ever been convicted of a violation of a federal law, state law, or municipal ordinance other than a minor traffic violation? YES ( ) NO (x)

If so, specify: _____
State or country Court Offense

_____
Date Disposition

5. Has your narcotic license ever been suspended, surrendered, or revoked? YES ( ) NO (X)

If so, specify: _____
Reason Date

6. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? YES ( ) NO (x)

If so, specify: _____
School, Hospital or Institution

_____
City/State Country

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Kade

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, CITY, STATE ZIP CODE, AND COUNTRY) (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADMIN.
7/85 - present	University of Cincinnati Hospital	234 Goodman Avenue Cincinnati, OH 45267	Resident Obstetrics & Gynecology	100%	

FORM 3

CERTIFICATE OF RECOMMENDATION

MUST BE COMPLETED FOR ALL APPLICANTS

This form is to be completed by a fully licensed physician in the state in which the form is notarized. The recommending physician should be sufficiently acquainted with the applicant for at least a six month period as to be able to evaluate and recommend the applicant. No relatives can serve as recommending physician. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

I, Paula Hilliard, a licensed and practicing physician in the state of
Recommending Physician

Ohio, affirm that Roslyn Kade has been known to me personally and professionally for 2 years and that he/she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as very good
His/her command of the English language is excellent
I rate his/her ability to work well with peers and medical staff as excellent
His/her relationship with patients is excellent

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend Roslyn Kade for full licensure to practice medicine in Ohio.
Applicant

Stanford University
Medical School of Graduation of Recommending Physician

Paula Hilliard
Signature of Recommending Physician

Ohio
State of Licensure of Recommending Physician

PAULA HILLIARD
Name of Recommending Physician (Please print)

#50490
License No. of Recommending Physician

213 Bethesda Avenue
Cinti, OH 45267-0526
Address of Recommending Physician

(513) 872-4796
Telephone Number (Include area code)

Subscribed and sworn to this 28 day of January, 19 87.

(SEAL)

Mary K. Oldony (McCarthy)
Notary Public

9-23-88
Date Commission Expires

UPON COMPLETION, RETURN TO:

State of Ohio
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43266-0315

87 JAN 30 P1:43
RECEIVED
OHIO STATE
MEDICAL BOARD

FORM 3

CERTIFICATE OF RECOMMENDATION

MUST BE COMPLETED FOR ALL APPLICANTS

This form is to be completed by a fully licensed physician in the state in which the form is notarized. The recommending physician should be sufficiently acquainted with the applicant for at least a six month period as to be able to evaluate and recommend the applicant. No relatives can serve as recommending physician. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

'87 FEB -3 PM 2:32

I, Tom P. Barden (Recommending Physician), a licensed and practicing physician in the state of Ohio, affirm that Roslyn Kade has been known to me personally and professionally for 3 years and that he/she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as above average.

His/her command of the English language is excellent

I rate his/her ability to work well with peers and medical staff as very good.

His/her relationship with patients is excellent

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend Roslyn Kade (Applicant) for full licensure to practice medicine in Ohio.

Indiana University
Medical School of Graduation of Recommending Physician

T. P. Ba
Signature of Recommending Physician

Ohio
State of Licensure of Recommending Physician

Tom P. Barden M.D.
Name of Recommending Physician (Please print)

30722
License No. of Recommending Physician

Dept. OB/GYN
University of Cincinnati Med. Ctr
Cincinnati, OH 45267-0526
Address of Recommending Physician

(513) 872-4796
Telephone Number (Include area code)

Subscribed and sworn to this 27 day of January, 19 87.

(SEAL)

Mary K Oldang (McCarthy)
Notary Public

9-23-88
Date Commission Expires

UPON COMPLETION, RETURN TO:

State of Ohio
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43266-0315

RECEIVED
ATTORNEY GENERAL'S OFFICE
JAN 30 1987
CRIME VICTIMS COMPENSATION

SECTION 7: Examination Scheduling Request (To be completed by applicants for examination only)

1. I wish to apply for the June ( ) December ( ) _____ FLEX examination.
Fill in year

Indicate which FLEX examination you are applying to take by placing an "X" next to the appropriate month and filling in the appropriate year.

SECTION 8: Photograph, Photoslip, and Certificates of Recommendation (Form 3)

1. Certificates of Recommendation (Form 3) must be completed by two fully licensed physicians. The physicians must be licensed in the state in which the form is notarized. A Form 3 is enclosed for each recommending physician. Each recommending physician must also sign your photoslip as indicated below. The Certificates of Recommendation must be notarized. THE PHYSICIANS MUST HAVE KNOWN THE APPLICANT FOR AT LEAST A SIX MONTH PERIOD. NO RELATIVES CAN SERVE AS RECOMMENDING PHYSICIANS FOR FORM 3.

2. You must submit a recent color photograph. Attach the photoslip enclosed in the application to this photo. Sign and date the back of the photo and print your name. Have each of the physicians who signed your recommendation forms also sign the photoslip.

87 FEB -4 P2:44

SECTION 9: Release of Applicant

STATE OF Ohio

COUNTY OF Hamilton ss:

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the State Medical Board of Ohio any information, files, or records requested by the Board in connection with this application. I further authorize the State Medical Board of Ohio to release to the organizations, individuals, or groups listed above any information which is material to my application.

Roslyn G. Kade
(Signature of Affiant)

Subscribed and sworn to this 3 day of February, 19 87

Mary K. Olding (McCarthy)
(Signature of Official Administering Oath)

9/29/88
(Date Commission Expires)

(SEAL)

Must be sworn to before a notary public or other person authorized to administer oaths.

SECTION 10: Affidavit of Applicant

STATE OF Ohio SS:

COUNTY OF Hamilton

Before me, personally appeared Roslyn G. Kade
(Affiant)

who being duly sworn says that She is the person referred to in the foregoing application for license to practice medicine and surgery or osteopathic medicine and surgery in the State of Ohio; that the statements therein and the documents or copies of documents attached thereto are strictly true in every respect and that She has read and understands this Affidavit.

Roslyn G. Kade
(Signature of Affiant)

Subscribed and sworn to this 3rd day of February, 19 87.

(SEAL)

Mary K. Olding (McCarthy)
(Signature of Official Administering Oath)

9/23/88
(Date Commission Expires)

*Must be sworn to before a notary public or other person authorized to administer oaths.

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

No. 70418

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

Ray 2. Bumgarner
Entrance Examiner

Henry S. Cramblett M.D.
Secretary

2-2787
Date Issued

FOR BOARD USE ONLY

#54939

NAME: Kade, Roslyn

CERTIFICATE NO. 70418 DATE ISSUED 2-2787

FILED Jan. 21, 1987

FEE $175.00

DETERMINATION:

BOARD ACTION: Appr. 2/87 PV

BASIS OF LICENSURE:

Revised:

34-10-47
2-6-87
185.00 pd
672

State of Ohio
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43266-0315

CENSUS BLANK

My name IN FULL is Kade (Last) Roslyn (First) Glenore (Middle)

Place of birth Philadelphia, Pa. Date of birth 07 (Month) 19 (Day) 51 (Year)

Permanent or home address 3703 Ault Park Ave (Number, Street) Cinti (City) OHIO (State) 45208 (Zip)

Present mailing address 3703 Ault Park Ave (Number, Street) Cinti (City) OHIO (State) 45208 (Zip)

I have attended school as follows: (State name, location, and whether high school, undergraduate school or college)

Denison University for 4 years, from 9/69 (Month/Year) to 6/73 (Month/Year)

College of William + Mary for 1½ years, from 9/78 (Month/Year) to 12/79 (Month/Year)

University of Cincinnati for 1½ years, from 7/80 (Month/Year) to 6/81 (Month/Year)

Graduated from University of Cincinnati College of Medicine (College, University, etc.)

located at Cincinnati (City) Ohio (State) USA (Country) in 1985 (Year) Degree MD

RSB

Roslyn Kade (Signature of Applicant) 2/2/87 (Date)

70418

FEB 1 P2:43

1 Roslyn Kade
Signature of Applicant

2 Roslyn Kade
Signature of Applicant

DATE PHOTOGRAPH TAKEN 2/2/87

I hereby certify that the photograph on the reverse side to which this slip is pasted is a genuine likeness of

Roslyn Kade
Applicant's Name (Please print)

who was recommended by me to the State Medical Board for a license to practice in Ohio.

1 Tom P. Gan
Signature of First Endorser

2/2/87
Date

2 Paula Hill
Signature of Second Endorser

2/2/87
Date

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Roslyn G. Kade, M. D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa.

07/01/86

Certificate # 87 FEB 17 A11:22

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from U CINCINNATI COL MEDICINE in JUNE 1985 and whose birth date is 07/19/195. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/83		
Anatomy, incl. histology and embryology	520	82
Physiology	340	70
Biochemistry	450	77
Pathology	530	82
Microbiology, incl. immunology	530	82
Pharmacology and Materia Medica	450	77
Behavioral Sciences	595	87
TOTAL TEST (Minimum Passing Score 380/75)	480	79
Part II passed 09/84		
Internal medicine and the medical specialties	520	83
Surgery and the surgical specialties	485	81
Obstetrics and Gynecology	630	88
Public Health and Preventive Medicine	430	79
Pediatrics	515	83
Psychiatry	470	81
TOTAL TEST (Minimum Passing Score 290/75)	510	82
PART III passed 03/86		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	490	81.7
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		80.9

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Melanie Valente
Secretary for Certification

SEAL

02/11/87
Date

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: KADE, Roslyn Glenore

SCHOOL OF GRADUATION: University of Cincinnati

SCHOOL LOCATION: Cincinnati, OH

DATE DEGREE CONFERRED: 6/9/85 DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY : University of Cincinnati Cincinnati, OH 7/85-present

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/86

GENERAL AVERAGE: 80.9%

LETTERS OF RECOMMENDATION: Paula Hillard, MD Cincinnati, OH

Tom P. Barden, MD Cincinnati, OH

SPECIALTY:

SPECIALTY BOARDS:

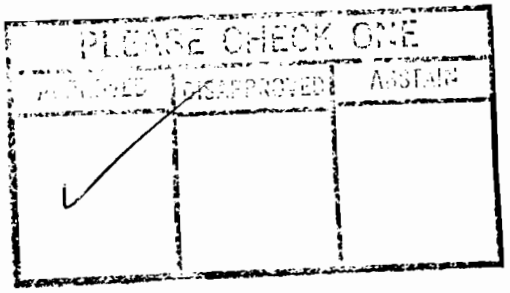
AMA INFORMATION : ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:



FEB 24 1987

CAROL ROLFES

City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Kade

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, CITY, STATE ZIP CODE, AND COUNTRY) (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADMIN
7/85 - present	University of Cincinnati Hospital	234 Goodman Avenue Cincinnati, OH 45267	Resident Obstetrics & Gynecology	100%	

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: KADE, Roslyn Glenore

SCHOOL OF GRADUATION: University of Cincinnati

SCHOOL LOCATION: Cincinnati, OH

DATE DEGREE CONFERRED: 6/9/85 DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY : University of Cincinnati Cincinnati, OH 7/85-present

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/86

GENERAL AVERAGE: 80.9%

LETTERS OF RECOMMENDATION: Paula Hillard, MD Cincinnati, OH

Tom P. Barden, MD Cincinnati, OH

SPECIALTY:

SPECIALTY BOARDS:

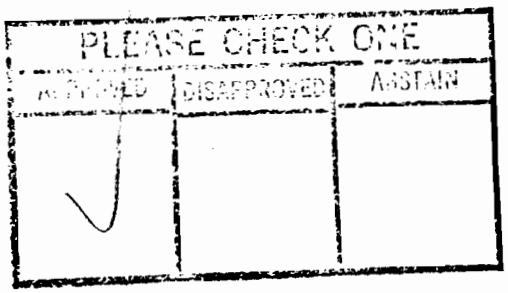
AMA INFORMATION : ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:



FEB 24 1987

HENRY G. CRAMBLETT, M.D.

City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Kade

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, CITY, STATE ZIP CODE, AND COUNTRY) (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADMIN
7/85 - present	University of Cincinnati Hospital	234 Goodman Avenue Cincinnati, OH 45267	Resident Obstetrics & Gynecology	100%	

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: KADE, Roslyn Glenore

SCHOOL OF GRADUATION: University of Cincinnati

SCHOOL LOCATION: Cincinnati, OH

DATE DEGREE CONFERRED: 6/9/85 DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY : University of Cincinnati Cincinnati, OH 7/85-present

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/86

GENERAL AVERAGE: 80.9%

LETTERS OF RECOMMENDATION: Paula Hillard, MD Cincinnati, OH

Tom P. Barden, MD Cincinnati, OH

SPECIALTY:

SPECIALTY BOARDS:

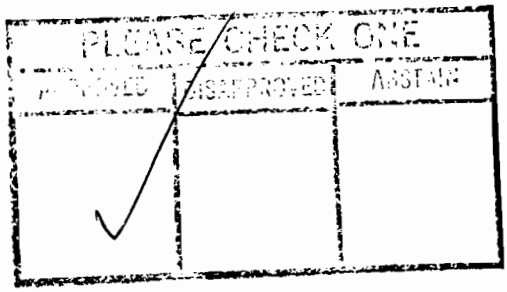
AMA INFORMATION : ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:



AUG 24 1987

TIMOTHY L. STEPHENS JR., M. D.

City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Kade

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, CITY, STATE ZIP CODE, AND COUNTRY) (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADMIN
7/85 - present	University of Cincinnati Hospital	234 Goodman Avenue Cincinnati, OH 45267	Resident Obstetrics & Gynecology	100%	

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: KADE, Roslyn Glenore

SCHOOL OF GRADUATION: University of Cincinnati

SCHOOL LOCATION: Cincinnati, OH

DATE DEGREE CONFERRED: 6/9/85 DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY : University of Cincinnati Cincinnati, OH 7/85-present

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/86

GENERAL AVERAGE: 80.9%

LETTERS OF RECOMMENDATION: Paula Hillard, MD Cincinnati, OH

Tom P. Barden, MD Cincinnati, OH

SPECIALTY:

SPECIALTY BOARDS:

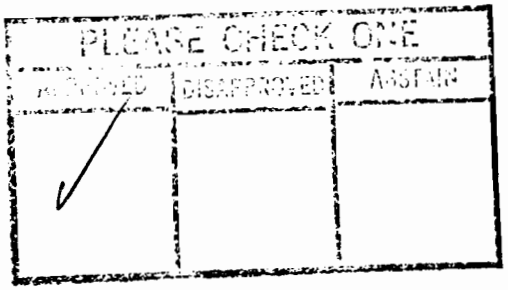
AMA INFORMATION : ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:



FREDRIC B. ROTHMAN, M.D.

FEB 2 6 1987

City/State Country

SECTION 6: Resume

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Kade

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, CITY, STATE ZIP CODE, AND COUNTRY) (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADMIN
7/85 - present	University of Cincinnati Hospital	234 Goodman Avenue Cincinnati, OH 45267	Resident Obstetrics & Gynecology	100%	

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: KADE, Roslyn Glenore

SCHOOL OF GRADUATION: University of Cincinnati

SCHOOL LOCATION: Cincinnati, OH

DATE DEGREE CONFERRED: 6/9/85 DEGREE CONFERRED: M.D.

INTERNSHIP:

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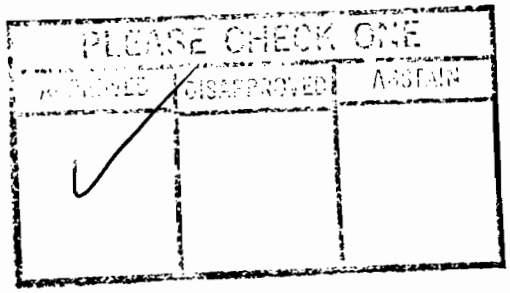

FEB 2 4 1987

JAMES [illegible], M.D.

City/State Country

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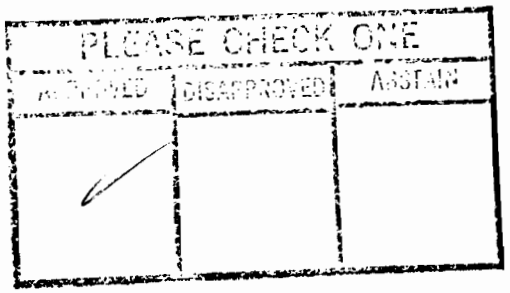

FEB 24 1987 WILLIAM W. JOHNSTON

FEB 24 ...

City/State Country

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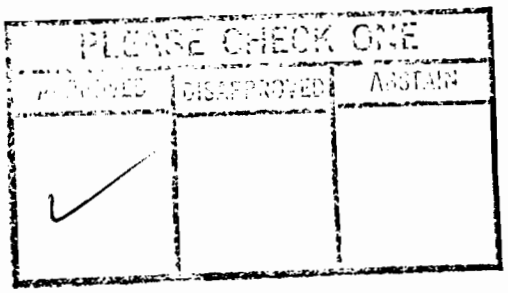

JOHN H. BUCHAN, D.P.M.

FEB 24 1987

City/State Country

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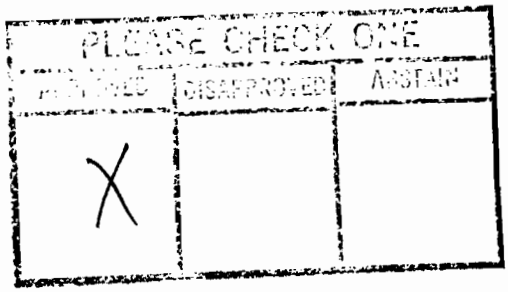

LEONARD L. LOVSHIN, M.D.

FEB 24 1987

City/State Country

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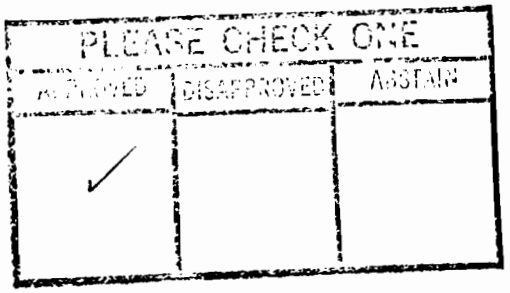

JOHN E. RAUCH, D.O.

FEB 24 1987

City/State Country

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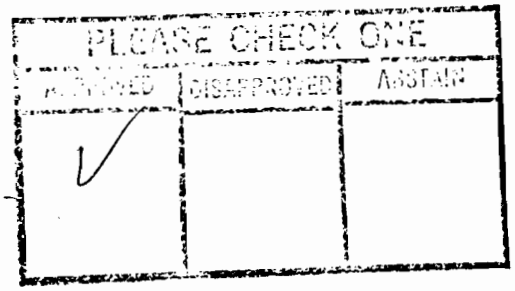

PETER LANCIONE, M. D.

FEB 24 1987

City/State Country

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STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

RECEIVED
FEB 17 1987

The Ohio State Medical Board requests a disciplinary search concerning the following individual:

Roslyn Glenore Kade, MD
Name

3703 Ault Park Ave.
Address

Cincinnati, OH 45208
City, State and Zip

7/19/51
Date of Birth

'87 FEB 23 P12:15
RECEIVED
OHIO STATE MEDICAL BOARD

Social Security Number

Univ of Cincinnati
Medical School of Graduation and Branch Location

1985
Date of Graduation

Please mail the response to the following address:

Ohio State Medical Board
65 S. Front St., Suite 510
Columbus, Ohio 43215

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN
FEB 17 1987
Bryant L. Galusha, M.D.
BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE-PRESIDENT

ATTENTION: Mindy Booth

Mindy Booth
Signature

State of Ohio
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43266-0315

DATE 2/12/87

Dear Doctor,

Dr. Rosyln Kade who is/was Resident OB/GYN 7/85-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 papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 3 yrs.

(2) What was/is your supervisory capacity? teacher.

(3) At what hospital? University of Cincinnati Hospital

(4) How would you rate this doctor's medical knowledge and techniques? above average.

(5) In your opinion, is this doctor a person of good moral and ethical character? yes.

(6) Does this doctor 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) NA

(9) Would you recommend this doctor for licensure? yes.

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

Please return this form to the Ohio State Medical Board at the above address,
Sincerely,

Mindy Booth
Mindy Booth
Assistant to the Chief of Licensure

'87 FEB 18 P4:16
OHIO STATE MEDICAL BOARD
RECEIVED

T. P. Barden
Signature of Doctor, please type or print name legibly beneath

TOM P. BARDEN

Professor & Chairman
Position

DATE

Telephone No. 513 872 4796 (Include Area Code)

The Board of Trustees of the

University of Cincinnati

on the recommendation of the Faculty of the

College of Medicine

of the University, does hereby confer upon

Roslyn Gleanre Kade

the degree of

Doctor of Medicine

with all the rights and privileges appertaining thereto. Given at Cincinnati, Ohio this ninth day of June, nineteen hundred and eighty five.

Chairman of the Board of Trustees

Secretary of the Board of Trustees

President of the University

Senior Vice President for the Medical Center and Dean, College of Medicine

2/3/87 Document is a true copy of original medical school diploma.

Mary K. Oldenburg McCarthy

Notary Public (commission expires 9/23/88)

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO
DIVISION OF DOMESTIC RELATIONS

IN THE MATTER OF :

MICHAEL MCKEEHAN HOLLINGSWORTH :

: Case No. A8309331

and

: File No. 126346E09

ROSLYN KADE HOLLINGSWORTH

: (Judge Wood)

Petitioners. :

DECREE OF DISSOLUTION
OF MARRIAGE

This matter came on for hearing upon the Petition of the parties for dissolution of marriage and the Separation Agreement of the parties attached thereto, the testimony of each party given under oath, and the report of the investigator. The Court finds that the Husband and Wife were residents of the State of Ohio for more than six months immediately prior to the filing of the Petition herein, that they were married as alleged in the Petition, that they have waived service of summons as provided in the Civil Rules, and that the matter was heard not less than thirty (30) days nor more than ninety (90) days after the filing of the Petition. The Court, therefore, finds that it has jurisdiction of the subject matter and of the parties. The Court further finds that both parties appeared before the Court at said hearing and acknowledged under oath that they voluntarily entered into the Separation Agreement appended to the Petition, that they were satisfied with the terms of the Separation Agreement, that they still desired dissolution of their marriage, and that the facts as set forth in their Petition are true.

It is ORDERED, ADJUDGED and DECREED that the marriage of the parties is hereby dissolved, and the Separation Agreement, a true and correct copy of which is attached hereto, is approved and incorporated as a part of this Decree.

Wife is hereby restored to her former name of Roslyn Glenore Kade.

2/3/87

Document is a true copy of original decree of dissolution of marriage.

Mary K. Olding McCarthy
Notary Public (commission expires 9/23/88)

2/3/87 Document is a true copy of original marriage license.

Mary K. Oldenburg (McCarthy)
Notary Public (commission expires 9/23/88)

No. _____

Original

I, Rev. Andrew B. Jellin hereby certify that on the 29th day of December, one thousand nine hundred and seventy-three at Philadelphia Richard H. Kellingsworth and Carolyn J. Kade

Were by me

United in Marriage

in accordance with License issued by the Clerk of the Orphans Court of Montgomery County, Pa., numbered _____

Andrew B. Jellin

Minister of the Gospel or Justice of the Peace

'87 FEB -4 P7:43

RECEIVED
OHIO STATE
MEDICAL BOARD

Roslyn G. Kade, M.D.

Women's Health Care
General Practice

March 7, 1991

State Medical Board of Ohio
77 S. High St. 7th Floor
Columbus, OH 43266-0315

Dear Sir/Madam:

I am writing to notify you of a change in address. If you have any questions please call.

old: Roslyn G. Kade, M.D.
Women's Center of Cincinnati
173 E. McMillan
Cincinnati, OH 45219

new: Roslyn G. Kade, M.D.
4341 Ashley Meadow Ct.
Cincinnati, OH 45227

Sincerely,

Roslyn G. Kade, M.D.

RGK/nle
Enclosure

Kade, Roslyn G.

update 3-14-91 sc

2123 Auburn Avenue, Suite 341 Cincinnati, Ohio 45219 (513) 723-0909

STATE MEDICAL BOARD

91 MAR 13 PM 2:54

STATE MEDICAL BOARD OF OHIO

EXPIRATION DATE
12/31/92

IDENTIFICATION NUMBER
35-05-4939

BE IT KNOWN THAT

1 1
9 ROSLYN GLENORE KADE, MD 9
9 WOMEN'S CENTER OF CINCINNATI 9
1 173 E. MCMILLAN 2
CINCINNATI OH 45219

STATE MEDICAL BOARD OF OHIO

HAS MET THE REQUIREMENTS OF THE LAW, IS DULY REGISTERED AND ENTITLED TO PRACTICE IN THE STATE OF OHIO UNTIL THE EXPIRATION DATE.

STATE MEDICAL BOARD OF OHIO

AUDIT NUMBER 021359

Please notify the board in writing, of any change in your address.

Please refer to your identification number on all correspondence with the board.

Ohio law requires that every physician's wall certificate be displayed in the physician's office or place where a major portion of such physician's practice is conducted.

STATE MEDICAL BOARD OF OHIO

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE [illegible] AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Roslyn Kade 10/21/88
(SIGNATURE OF APPLICANT) (DATE)

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. UPDATE SPECIALTY IF NEEDED.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO, BOX 2438, COLUMBUS, OHIO 43216

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A; DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-35-2939

ROSLYN GLENORE KADE
WOMEN'S CENTER OF CINCINNATI
173 E. MCMILLAN
CINCINNATI OH 45219

QT-00223-OF

MD & DO SPECIALTY CODES	
SPECIALTY CODES CURRENTLY ON RECORD	
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD) (LIMIT OF 3)	17 21

AMOUNT DUE $100.00 DATE DUE 11/01/88

REPORT ANY CHANGE OF ADDRESS OF RECORD (PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 1.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER Redacted

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☑	a.) a felony
☐	☑	b.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATION HAVE YOU:

YES	NO	
☐	☑	1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer no to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all statutory requirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.
☐	☑	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☑	3.) Surrendered or consented to limitation upon a license to practice medicine or state or federal privileges to prescribe controlled substances?
☐	☑	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-OB

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Roslyn Kade MD 10/25/90

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-05-4939	$160.00	11/01/90

ROSLYN GLENORE KADE, M.D.
WOMEN'S CENTER OF CINCINNATI
173 E. MCMILLAN
CINCINNATI OH 45219

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

17 GENERAL PRACTICE
21 GYNECOLOGY

☒ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935054939 11 "00000 16000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLEAD GUILTY OR NO CONTEST TO :

	YES	NO
A.) A felony		☒
B.) A federal or state law regulating the possession, distribution or use of any drug?		☒

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

	YES	NO
1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.		☒
2.) Had any disciplinary action taken or initiated against you by any state licensing board?		☒
3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		☒
4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?		☒

SOCIAL SECURITY NUMBER Redacted
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 9/3/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35054939	$160.00	07/01/92

ROSLYN GLENORE KADE,M.D.
4341 ASHLEY MEADOW CT
CINCINNATI OH 45227

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

17 GENERAL PRACTICE
21 GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

2123 AMERICAN AVE SUITE 504
STREET
STREET
CINCINNATI OH 45212
CITY STATE ZIP CODE
HAMILTON
COUNTY

:96969696 21: 0935054939" "00000160000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NO CONTEST TO :

YES	NO	
	☑	A.) A felony or misdemeanor.
	☑	B.) A federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES	NO	
	☑	1.) 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? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.
	☑	2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?
	☑	3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?
	☑	4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] MD 4/20/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-4939	$250.00	05/01/94

ROSLYN GLENORE KADE,M.D.
2123 AUBURN AVE
SUITE 341
CINCINNATI OH 45219

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GP GENERAL PRACTICE
GYN GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET 711 E HALLISTER
STREET
CITY CINCINNATI STATE OH ZIP CODE 45219
COUNTY HAMILTON

⑆969696962⑆ 0935054939⑈ ⑉0000025000⑉

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street 711 East Hollister
Street
City Cincinnati State OH Zip Code 45219
County Hamilton

930 00137 [illegible] 2894 012[illegible] 250.00 042794 935054939
TAX BATCH # DATE SEQ MC# AMOUNT BATCHDATE ACCOUNT #

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES ☐ NO ☑ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES ☐ NO ☑ 3.) 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? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES ☐ NO ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES ☐ NO ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES ☐ NO ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES ☐ NO ☑ 8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Roslyn Kade MD
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-4939	$250.00	05/01/96

ROSLYN GLENORE KADE,M.D.
71 E HOLLISTER
CINCINNATI OH 45219

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GP GENERAL PRACTICE
GYN GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

⑆9696969621⑆ 0935054939⑈ ⑈0000025000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES ☐ NO ☒

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☒

3.) 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? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES ☐ NO ☒

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES ☐ NO ☒

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES ☐ NO ☒

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES ☐ NO ☒

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES ☐ NO ☒

8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement? YES ☐ NO ☒

SOCIAL SECURITY NUMBER (Optional for purposes of identification)
[redacted]

888 00145 041696 001 250.00 041696 935054939
TAX-BATCH P. DATE SEQ. NO. AMOUNT BATCHDATE ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X R. Kade MD
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-4939-K	$275.00	05/01/98

ROSLYN GLENORE KADE,M.D.
71 E HOLLISTER
CINCINNATI OH 45219

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GP GENERAL PRACTICE
GYN GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 0935054939 00000027500

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO
☐ ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO
☐ ☑ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO
☐ ☑ 3.) 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? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO
☐ ☐ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? Pie ligu doctor

YES NO
☐ ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO
☐ ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO
☐ ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO
☐ ☑ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43266-0315 • (614) 466-3934 • Website: www.state.oh.us/med/

Date: April 6, 1998

Roslyn G. Kade, M.D.
71 E. Hollister
Cincinnati, OH 45219

APR 08 1998

Dear Doctor:

Please be advised that in reviewing your renewal application card for your Ohio license, we find that you failed to answer the following question(s). To continue processing your renewal, answer each checked question below:

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU: (only those questions marked with a ✓ apply to you)		YES	NO
☐	1.) *Been found guilty of, or pled guilty or no contest to a felony or misdemeanor?*	☐	☐
☐	2.) *Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?*	☐	☐
☐	3.) *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? You may answer "NO" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*	☐	☐
☒	4.) *Had malpractice insurance canceled or limited for other than failure to pay premiums?*	☐	☑
☐	5.) *Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?*	☐	☐
☐	6.) *Surrendered, or consented to limitation upon: a) a license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?*	☐	☐
☐	7.) *Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?*	☐	☐
☐	8.) *Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?*	☐	☐
☐	YOU DID NOT ANSWER ANY OF THE QUESTIONS. ANSWER EACH QUESTION (1 - 8) ABOVE.		

OVER ⇨

I certify, that the information provided is true and correct.

Roslyn Kade — Signature of Applicant

4.16.98 — Date

Upon completion of this form, return directly to the Board. If your response is not received in this office by October 1, 1998, your Ohio license will lapse by action of law.

Should you have any questions concerning this information, please contact me at the address indicated on the other side.

Sincerely,

Debra L. Jones

Debra L. Jones, Chief
C.M.E., Records and Renewal

DLJ:jdc

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X R. Kade MD 7-10-00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-4939-K	$305.00	07/01/2000

ROSLYN GLENORE KADE,M.D.
71 E HOLLISTER
CINCINNATI OH 45219

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GP GENERAL PRACTICE
GYN GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

ABA Ashview Medical Ctr
STREET
STREET
Cincinnati OH 45227
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935054939 ,00000305 00,

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor? YES ☐ NO ☑

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☑

3.) 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? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions; or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES ☐ NO ☐

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES ☐ NO ☑

5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you? YES ☐ NO ☑

6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances? YES ☐ NO ☑

7.) Had any clinical privileges or other authority to practice suspended,restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES ☐ NO ☑

REQUIRED: [redacted] Redacted
SOCIAL SECURITY NUMBER

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION IN COMPLIANCE WITH O.R.C. 4731.281 AND O.A.C. 4731-10, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 054939	305.00	7/1/2004	10/1/2004

Dr. ROSLYN GLENORE KADE
4341 ASHLEY MEADOW CT
CINCINNATI OH 45227

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GP

GYN

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

4341 Ashley Meadow Ct
STREET
STREET
Cincinnati OH 45227
CITY STATE ZIP CODE
Hamilton
COUNTY

SELECT ONE ADDRESS FOR MAILINGS FROM THE BOARD.
☐ RESIDENCE ☑ PRINICIPAL PRACTICE ADDRESS

0003662165 30500 35ZZ 054939

APPLICATION FOR LICENSURE / RENEW
IN OHIO :

	YES	NO
1.) Have you been fou guilty of, or pled guilty or contest to, or receiv treatment or intervention lieu of conviction of, a felo or misdemeanor?	☐	☑
2.) Have you been addicted or dependent upon alcohol any chemical substance; been treated for, or be diagnosed as suffering fro drug or alcohol dependen or abuse? **You may answ "NO" to this question if y** have successfully complet treatment at, or are currentl enrolled in, a program approv by this Board and have adhered to all statutory requiremer during and subsequent to treatment. You must answer "YE if you have ever relapsed. Any questions concerning progra approval or concerning this question can be directed to t board offices.	☐	☑
3.) Have any malpractice awards or settlemen been paid by you or on your behalf for ac occurring in any state other than Ohio?	☐	☑
4.) Has any board, bureau, department, agency, other body, including those in Ohio, **other th this board**, filed any charges, allegations complaints against you?	☐	☑
5.) Have you surrendered, or consented limitation of, or to suspension, reprimand probation concerning, a license to practice a healthcare profession or state or feder privileges to prescribe controlled substances any jurisdiction? You may answer "NO" to th question if the only such surrender or conse was given to this board.	☐	☑
6.) Have you had any clinical privileges or oth similar institutional authority suspended, restrict or revoked for reasons **other than failure maintain records on a timely basis or to atte staff meetings?**	☐	☑

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

Redacted
Street
Street
City State Zip Code
County

Date Posted: 5/4/2006 11:17:08 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

BUSINESS ADDRESS	71 E HOLLISTER CINCINNATI, OH 45219 Hamilton County United States of America 513-723-0909
CREDENTIAL MAIL ADDRESS	71 E Hollister Street Cincinnati, OH 45219 Hamilton County United States of America 513-723-0909
MAIN	4341 ASHLEY MEADOW CT CINCINNATI, OH 45227 Hamilton County United States of America 513-271-5245

License Information

License Number	35.054939
License Name	ROSLYN KADE
Email Address	

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . 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 other similar institutional authority suspended, restricted or revoked 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?

. . . . . YES

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}*

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

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

Date Posted: 5/17/2008 10:37:54 AM

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

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

License Information

License Number	35.054939
License Name	ROSLYN KADE
Email Address	drskkh@one.ent

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . 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 other similar 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}*

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

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

Date Posted: 4/27/2010 4:09:09 PM

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

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

Address Information

BUSINESS ADDRESS	71 E HOLLISTER CINCINNATI, OH 45219 Hamilton County United States of America 513-723-0909 lprovidenti@nuvox.net
CREDENTIAL MAIL ADDRESS	71 E Hollister Street Cincinnati, OH 45219 Hamilton County United States of America 513-723-0909 lprovidenti@nuvox.net

License Information

License Number	35.054939
License Name	ROSLYN KADE

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   ..... 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 other similar 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}*

I understand that submitting a false, fraudulent, or forged statement or

document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

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

Date Posted: 6/28/2012 11:55:40 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

BUSINESS ADDRESS	71 E HOLLISTER CINCINNATI, OH 45219 Hamilton County United States of America 513-723-0909 kandklaurap@gmail.com
CREDENTIAL MAIL ADDRESS	71 E Hollister Street Cincinnati, OH 45219 Hamilton County United States of America 513-723-0909 kandklaurap@gmail.com

License Information

License Number	35.054939
License Name	ROSLYN KADE

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

. . . . . 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 other similar 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

. 30-34

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

. 0

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.)

. 5-9

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

. 0

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).

. 30-34

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

. 0

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

. 0

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:

. 45219

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45241

4. Enter the second county:

. . . . . Hamilton

5. Enter the third zip code:

. 45429

6. Enter the third county:

. . . . . Montgomery

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

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.

Date Posted: 6/24/2014 5:21:35 PM

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

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

Address Information

BUSINESS ADDRESS	PPSWO 2314 Auburn Ave CINCINNATI, OH 45219 Hamilton County United States of America 513-824-7866 rkade@ppswo.org
CREDENTIAL MAIL ADDRESS	PPSWO 2314 Auburn Ave Cincinnati, OH 45219 Hamilton County United States of America 513-824-7866 rkade@ppswo.org

License Information

License Number	35.054939
License Name	ROSLYN KADE

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

. . . . . GENERAL PRACTICE

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

. . . . . GYNECOLOGY

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. At any time since signing your last application for renewal of your certificate 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. At any time since signing your last application for renewal of your certificate 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. At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. At any time since signing your last application for renewal of your certificate 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. At any time since signing your last application for renewal of your certificate have you had any clinical privileges or other similar 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. At any time since signing your last application for renewal of your certificate have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, 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?

. . . . . YES

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.**

. . . . . Julie Castellanos, CNP; Melinda Chimento, CNP; Jessica Crider, CNP; Tracy Dillingham, CNP,CNM; Sarah King, CNP; Rebecca Roce, CNP; Gwynne Rohrs, CNM; Michelle Schlarmann, CNP; Audra Trillana CNP; Misty Uhl, CNP; Beverly Wells, CNP; Crystal Wilmhoff, CNP

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

. 0

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.)

. 20-24

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

. 0

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)".

. 0

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

. 0

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

. 0

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

. 20-24

Workforce Counties

1. Enter the first zip code:

. 45219

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45429

4. Enter the second county:

. . . . . Montgomery

5. Enter the third zip code:

. 45011

6. Enter the third county:

. . . . . Butler

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 2314 Auburn Ave, Cincinnati, OH 45219; 834 OH Pike, Withamsville, OH 45245; 2016 Ferguson Dr, Cincinnati, OH 45238; 290 Northland Blvd, Springdale, OH 45246; 224 N. Wilkinson St, Dayton, OH 45402; 11 Ludlow Ave, Hamilton, OH 45011; 1061 N. Becthtle Ave, Springfield, OH 45504; 1401 E. Stroop Rd, Dayton, OH 45429

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . 10+

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?

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Spanish

2. Select a language from the drop down list.

. . . . . *{not Answered}*

3. Select a language from the drop down list.

. . . . . *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1497859995

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . BK1147710

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.