State Medical Board of Ohio

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

Ohio Physician Licensure Application Addendum

1. *Indicate License Type* (•) M.D. ( ) D.O. ( ) M.D. Telemedicine ( ) D.O. Telemedicine

2. *Name: Indicate your full legal name. Please list any maiden names or other names used.*

Last	First	Middle	Suffix
Kalsy	Sapna		

Maiden Name:

All other names used:

3. *Contact Information:* *Please complete all sections*

Indicate which address you wish to use for mailings from the Medical Board. ( ) Practice Address (•) Home Address

Practice Address

Street 1: Phone Number:

Street 2: Fax Number:

City: State: Zip Code: email:

Home Address

Street 1: 153 Cooper's Hawk Lane Phone Number: +1 (336) 655-2544

Street 2: Fax Number:

City: Landenberg State: PA Zip Code: 19350 email: skalsy@me.com

4. *Identification*

Date of birth	Birth City	State	Country
08/28/1977	Torrance	CA	USA

SSN: REDACTED

Gender: ( ) Male (•) Female

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760., 4762., or 4778. O.R.C. or as otherwise required by state or federal law.

SEP 0 4 2014 129732 Kalsy, Sapna

5. Preliminary Education.

High School or equivalent: The Hotchkiss School

City Lakeville State CT Country USA

Date From 09/1991 Date To 06/1995

Undergraduate College 1 Tufts University

City Medford State MA Country USA

Date From 09/1995 Date To 06/1999 Degree Bach. of Science, Minor Fine Arts

Undergraduate College 2

City State Country

Date From Date To Degree

6. TOEFL- IBT. This section is only required to be completed by International Medical School Graduates.

The TOEFL, TWE, ECFMG's ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL-IBT.

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

○ YES ○ NO Have you completed two years of undergraduate college work in the United States?

○ YES ○ NO During the five years immediately preceding the date of your application have you:

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?

○ YES ○ NO Have you completed a Fifth Pathway program?

○ YES ○ NO Have you passed the Clinical Skills Assessment exam given by the ECFMG on or before July 1, 1998?

If you answered 'NO' to all of the above, you are required to take the TOEFL-IBT. Please refer to the instructions for information on contacting the Educational Testing Service. The Board cannot waive this requirement.

7. Ohio Training Program.

○ YES ◉ NO Are you or will you be in an accredited training program in Ohio? If yes, please identify the program below.

Program Name

8. Military.

○ YES ◉ NO Are you currently in the United States Military or Reserves or a Military Veteran?

○ YES ◉ NO Are you the spouse of an individual currently serving in the United States Military or Reserves?

MEDICAL BOARD

AUG 29 2014

4. Hospital Name | Date From
Address | Date To
City | State | Zip Code
Country | Successfully Completed? ○ Yes ○ No
Department/Specialty:

PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other

PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

5. Hospital Name | Date From
Address | Date To
City | State | Zip Code
Country | Successfully Completed? ○ Yes ○ No
Department/Specialty:

PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other

PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

11. Examination History: *List each licensure examination you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, copy and attach an additional sheet.*

Examination	Date Taken (mm,yyyy)	Pass / Fail	No. of Attempts
USMLE Step 1	06,2003	◉ Pass ○ Fail	1
USMLE Step 2 CK	01,2005	◉ Pass ○ Fail	1
USMLE Step 2 CS	04,2005	◉ Pass ○ Fail	1
USMLE Step 3	12,2007	◉ Pass ○ Fail	1
COMLEX Level 1		○ Pass ○ Fail	
COMLEX Level 2 CE		○ Pass ○ Fail	
COMLEX Level 2 PE		○ Pass ○ Fail	
COMLEX Level 3		○ Pass ○ Fail	
NBME Part I		○ Pass ○ Fail	
NBME Part II		○ Pass ○ Fail	
NBME Part III		○ Pass ○ Fail	
NBOME Part I		○ Pass ○ Fail	
NBOME Part II		○ Pass ○ Fail	
NBOME Part III		○ Pass ○ Fail	
LMCC Part I		○ Pass ○ Fail	
LMCC Part II		○ Pass ○ Fail	
FLEX Componet 1		○ Pass ○ Fail	
FLEX Componet 2		○ Pass ○ Fail	
FLEX Pre-1985		○ Pass ○ Fail	

State Board Exam | Date Taken | State taken for | No. of Attempts | Pass / Fail ○ Pass ○ Fail

9. Medical School: *List all medical schools you have attended, including those from which you did not graduate in chronological order. Attach and additional sheet if necessary.*

1. School Name: Drexel University College of Medicine
Address: 2900 Queen Lane
City: Philadelphia State: PA Zip Code: 19129
Country: USA
Date From: 08/01/2001
Date To: 05/20/2005
Graduation Date: 05/20/2005
Degree: Doctorate of Medicine

2. School Name:
Address:
City: State: Zip Code:
Country:
Date From:
Date To:
Graduation Date:
Degree:

10. Postgraduate Training: *List all postgraduate programs you have attended, including those you did not complete. Copy and attach additional pages if necessary.*

1. Hospital Name: Wake Forest University Baptist Medical Center
Address: 1 Medical Center Blvd
City: Winston-Salem State: NC Zip Code: 27103
Country: USA
Department/Specialty: Ob/Gyn Residency
Date From: 06/24/2005
Date To: 10/27/2007
Successfully Completed? ○ Yes ◉ No
PGY ○ 1 ◉ 2 ○ 3 ○ 4 ○ 5 ○ other
PGT ○ Internship ◉ Residency ○ Fellowship ○ Research ○ other

2. Hospital Name: University of North Carolina Hospitals
Address: 333 South Columbia St, MacNider Hall, Room #348/CB # 7240
City: Chapel Hill State: NC Zip Code: 27599-7240
Country: USA
Department/Specialty: Dept. of Social Medicine/Preventive Medicine Residency
Date From: 07/01/2008
Date To: 06/30/2010
Successfully Completed? ◉ Yes ○ No
PGY ○ 1 ○ 2 ○ 3 ◉ 4 ○ 5 ○ other
PGT ○ Internship ◉ Residency ○ Fellowship ○ Research ○ other

3. Hospital Name:
Address:
City: State: Zip Code:
Country:
Department/Specialty:
Date From:
Date To:
Successfully Completed? ○ Yes ○ No
PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other
PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

12. *ECFMG and Fifth Pathway*

Certificate Number | Issue Date

School Name | Date From
Address | Date To
City | State | Zip Code | Graduation Date
Country | Degree

13. *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 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 the 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. (Attach additional pages if necessary).*

	State / Province	License Type	License Number	License Status		Issue Date
1	North Carolina	Medical	2008-00417	(•) Active	( ) Inactive	03/31/2008
2	South Carolina	Medical	34231	(•) Active	( ) Inactive	02/22/2012
3	California	Phsycian + Surg	126263	( ) Active	( ) Inactive	06/26/2013
4				( ) Active	( ) Inactive	
5				( ) Active	( ) Inactive	
6				( ) Active	( ) Inactive	
7				( ) Active	( ) Inactive	
8				( ) Active	( ) Inactive	
9				( ) Active	( ) Inactive	
10				( ) Active	( ) Inactive	
11				( ) Active	( ) Inactive	
12				( ) Active	( ) Inactive	
13				( ) Active	( ) Inactive	
14				( ) Active	( ) Inactive	
15				( ) Active	( ) Inactive	

14. *Specialty Board Certification:* *Are you ABMS and / or AOA certified?* (•) Yes ( ) No

*If **Yes** complete information below*

Name of Board	American Board of Preventive Medicine	Certificate Number	53143	Issue Date	01/01/2013
Name of Board		Certificate Number		Issue Date	
Name of Board		Certificate Number		Issue Date	

15. Chronology of Activities: *List ALL activities (medical, non-medical, and postgraduate training) 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 SUBSTITUTE ANY OTHER RESUME FOR THIS FORM****. Be sure to indicate the percentage of working time spent in clinical /administrative duties.*

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 06 Year: 2005

TO: Month: 10 Year: 2007 ☐ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Ob/Gyn Resident

Activity Address: 1 Medical Center Blvd, Wake Forest Baptist Medical Center.

City: Winston-Salem State: NC Zip Code: 27103

Position / Department: Ob/Gyn Resident/Obstetrics and Gynecology Department

Percent Clinical: 100% Percent Administrative: 0%

☐ Employment ☐ Staff Privileges ☐ Administrative ◉ Other, Please describe below

Residency training in Obstetrics and Gynecology.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 10 Year: 2007

TO: Month: 06 Year: 2008 ☐ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Non-working

Activity Address: 3023 Diaz Lane

City: Winston-Salem State: NC Zip Code: 27103

Position / Department: Not Applicable

Percent Clinical: 0% Percent Administrative: 0%

☐ Employment ☐ Staff Privileges ☐ Administrative ◉ Other, Please describe below

Please see attached document for description.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 07 Year: 2008

TO: Month: 06 Year: 2010 ☐ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: General Preventive Medicine Resident

Activity Address: UNC Hospitals, 333 South Columbia St, MacNider Hall, Room #348/CB#7240

City: Chapel Hill State: NC Zip Code: 27599-7240

Position / Department: General Preventive Medicine Resident/ Department of Social Medicine

Percent Clinical: 0% Percent Administrative: 100%

☐ Employment ☐ Staff Privileges ☐ Administrative ◉ Other, Please describe below

Residency training in General Preventive Medicine.

15. Chronology of Activities: *List ALL activities (medical, non-medical, and postgraduate training) 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 SUBSTITUTE ANY OTHER RESUME FOR THIS FORM****. Be sure to indicate the percentage of working time spent in clinical /administrative duties.*

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 07 Year: 2010

TO: Month: 08 Year: 2010 ☐ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Non-working

Activity Address: 3023 Diaz Lane

City: Winston-Salem State: NC Zip Code: 27103

Position / Department: Not applicable

Percent Clinical: 0% Percent Administrative: 0%

☐ Employment ☐ Staff Privileges ☐ Administrative ◉ Other, Please describe below

Seeking employment and vacation.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 08 Year: 2010

TO: Month: 12 Year: 2012 ☐ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Planned Parenthood Health Systems, Inc.

Activity Address: 3000 Maplewood Ave, Ste 112

City: Winston-Salem State: NC Zip Code: 27103

Position / Department: Regional Lead Clinician/Medical Services

Percent Clinical: 70% Percent Administrative: 30%

◉ Employment ☐ Staff Privileges ☐ Administrative ☐ Other, Please describe below

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 01 Year: 2013

TO: Month: 07 Year: 2013 ☐ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Non-working

Activity Address: Switzerland

City: Bern and Zurich State: Zip Code:

Position / Department: Not applicable

Percent Clinical: 0% Percent Administrative: 0%

☐ Employment ☐ Staff Privileges ☐ Administrative ◉ Other, Please describe below

Living abroad for spouse travelling fellowship. Active in German language course + Suisse culture.

15. Chronology of Activities: *List ALL activities (medical, non-medical, and postgraduate training) 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 SUBSTITUTE ANY OTHER RESUME FOR THIS FORM****. Be sure to indicate the percentage of working time spent in clinical /administrative duties.*

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 7 Year: 2013

TO: Month: 08 Year: 2013 ○ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Non-working

Activity Address: 1427 7th St, Apt 401

City: Santa Monica State: CA Zip Code: 90401

Position / Department: Not applicable

Percent Clinical: 0% Percent Administrative: 0%

○ Employment ○ Staff Privileges ○ Administrative ◉ Other, Please describe below

Relocation from Switzerland to California via Pennsylvania. In addition, seeking employment.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 09 Year: 2013

TO: Month: 07 Year: 2013 ○ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Planned Parenthood SBVSLO, Inc.

Activity Address: 518 Garden Street

City: Santa Barbara State: CA Zip Code: 93101

Position / Department: Contract Physician/Medical Services

Percent Clinical: 90% Percent Administrative: 10%

○ Employment ○ Staff Privileges ○ Administrative ◉ Other, Please describe below

Part-time contract physician providing clinical services and supervision of mid-level clinicians.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 11 Year: 2013

TO: Month: 06 Year: 2014 ○ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Northeast Community Clinics

Activity Address: 1400 S. Grand Ave, Suite 700

City: Los Angeles State: CA Zip Code: 90015

Position / Department: Contract Physician/Health Services

Percent Clinical: 100% Percent Administrative: 0%

○ Employment ○ Staff Privileges ○ Administrative ◉ Other, Please describe below

Part-time contract physician providing clinical services.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 02 Year: 2014

TO: Month: 08 Year: 2014 ◉ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Planned Parenthood Pacific Southwest

Activity Address: 1075 Camino del Rio South

City: San Diego State: CA Zip Code: 92108

Position / Department: Contract Physician/Medical Services

Percent Clinical: 100% Percent Administrative:

○ Employment ○ Staff Privileges ○ Administrative ◉ Other, Please describe below

Part-time contract physician providing clinical services.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: Year:

TO: Month: Year: ○ In Progress

Activity Name *(Practice/Employment/Non-Working*)*:

Activity Address:

City: State: Zip Code:

Position / Department:

Percent Clinical: Percent Administrative:

○ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

16. 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 provide a detailed written description of the background and medical issues involved in each case. Attach additional sheets if necessary.*

Name of patient involved: State action took place

Name of Court Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: Amount paid on your behalf

Month and Year of incident Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

Name of patient involved: State action took place

Name of Court Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: Amount paid on your behalf

Month and Year of incident Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

Ohio Addendum to Application
ADDITIONAL INFORMATION QUESTIONS

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.

○ Yes	◉ No	1. Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?
◉ Yes	○ No	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?
○ Yes	◉ No	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?
◉ Yes	○ No	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?
◉ Yes	○ No	5. Have you ever transferred from one graduate medical education program to another?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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?

August 21, 2014

To Whom It May Concern,

Please accept this explanation in response to the Additional Information Questions #2.

While an Obstetrics and Gynecology resident at Wake Forest University Baptist Medical Center, I received feedback from an instructor concerning misrepresented facts and assessment of a patient. This issue was resolved at the time this feedback was given.

As an OB/GYN resident, I had no restriction on privileges or limitation in practice. However, a plan of probation and remediation to improve my CREOG (national OB/GYN in-service examination) score and overall performance was discussed. This plan was to be from December 1, 2007-February 29, 2008. However, I resigned from the residency in October 2007 and thus was never placed under this proposed remediation plan.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Sapna Kalsy, MD, MPH

Sapna Kalsy, MD, MPH

August 21, 2014

To Whom It May Concern,

Please accept this explanation in response to the Additional Information Questions #4.

Between June 2005-October 2007, I was an Obstetrics and Gynecology resident at Wake Forest Baptist Medical Center. During this residency, I found my true interest was really in Preventive Medicine and Public Health. After much deliberation, in October 2007, I made the decision to pursue a career in Preventive Medicine/Public Health. As a result, I resigned my position as an Obstetrics and Gynecology resident at Wake Forest University Baptist Medical Center. I began residency in Preventive Medicine/Public Health at University of North Carolina on July 1, 2008 and I have been practicing in this field since this time.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Sapna Kalsy, MD, MPH

Sapna Kalsy, MD, MPH

August 21, 2014

To Whom It May Concern,

Please accept this explanation in response to the Additional Information Questions #5.

Between June 2005-October 2007, I was an Obstetrics and Gynecology resident at Wake Forest Baptist Medical Center. During this residency, I found my true interest was really in Preventive Medicine and Public Health. After much deliberation, in October 2007, I made the decision to pursue a career in Preventive Medicine/Public Health. As a result, I resigned my position as an Obstetrics and Gynecology resident at Wake Forest University Baptist Medical Center. I began residency in Preventive Medicine/Public Health at University of North Carolina on July 1, 2008 and I have been practicing in this field since this time.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Sapna Kalsy, MD, MPH

Sapna Kalsy, MD, MPH

○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	15. Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
○ Yes	◉ No	16. Have you ever been arrested, 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. Photocopies will not be accepted.
○ Yes	◉ No	17. Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.
○ Yes	◉ No	18. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?
○ Yes	◉ No	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?
○ Yes	◉ No	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?

○ Yes ◉ No 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?

○ Yes ◉ No 22. 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 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.

○ Yes ○ No 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.

○ Yes ○ No b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

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

○ Yes ◉ No 24. Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?

○ Yes ○ No 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.

○ Yes ○ No 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?

○ Yes ○ No 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.

This form must be completed if you have responded yes to Additional Information Question #I5 and/or #16.
Make additional copies of this form as needed.

Name of applicant

Date of incident

Location of Incident (City / State)

Were you arrested:

◯ Yes ◯ No

If the incident was alcohol-related, did you submit to a breath, blood, urine or other test to determine the amount of alcohol in your body?

If Yes, type if test and result

What offense(s) were you charged with?

Were the charges amended?:

◯ Yes ◯ No

If Yes, what were the final charges

Disposition:

◯ Pending ◯ Charges Dismissed ◯ Charges Dropped ◯ Conviction

◯ Plea

◯ Other

You must provide a detailed written explanation of the event including a description of the event, what led up to the event and what was learned. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach a separate sheet. Submit copies of the police report/arrest record, a copy of the charges or ticket, a copy of the final court disposition and any other relevant documentation

To Mail you application:

You cannot save data typed into this form. Please print 2 copies of your completed form. Keep one copy for your records and mail the other copy to:

State Medical Board of Ohio
30 E. Broad Street, 3rd Floor
Columbus, Ohio 43215

MEDICAL BOARD

AUG 29 2014

Print Form

State Medical Board of Ohio

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

Recommending physician, print name legibly

I Katherine Farris, MD, currently hold an active license to practice as a physician in the state of NC / license number 143375, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," the photograph affixed hereto is a genuine likeness of the applicant, and provide this recommendation form related to the request for professional licensure by SAPNA KALSY, MD

Applicant, print name legibly

1. How do you know this applicant ?
   Former Work Colleage
2. How would you describe the applicant's medical knowledge ?
   Excellent
3. How would you describe the applicant's clinical technique ?
   Excellent, thorough
4. How would you characterize the applicant's relationship with the patients ?
   Excellent manner
5. How would you the applicant's ability to work with peers and clinical staff ?
   Excellent, was a pleasure to work with
6. Have you personally known the applicant at least six months? ☒ Yes ☐ No
7. Does the applicant possess good moral character? (If no, explain) ☒ Yes ☐ No
8. Do you recommend this applicant for the professional license being sought? (If no, explain) ☒ Yes ☐ No
9. Are you aware of any information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐ Yes ☒ No

[illegible] attached additional correspondence or information to this form? ☐ Yes ☒ No

MEDICAL BOARD
OCT 6 2014

Signature of Recommending Physician (Name stamp not accepted)

Address (including house number and street, city ,state and zip code
3000 Maplewood Ave, Ste 112; Winston-Salem NC 27103

Notary Public Signature

Date Commission Expires 12/3/17

Subscribed and Sworn to before me on this 2nd day of October ,20 14

DEAN P. DOUCETTE NOTARY PUBLIC CATAWBA COUNTY, NC

State Medical Board of Ohio

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

Recommending physician, print name legibly

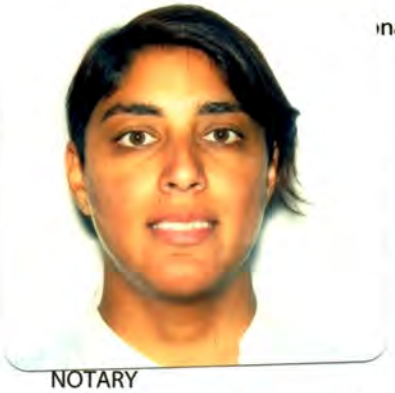
I Donna Le Burkett, currently hold an active license to practice as a physician in the state of Vermont / license number 042.0012727 attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," the photograph affixed hereto is a genuine likeness of the applicant, and provide this recommendation form related to the request for professional licensure by Sapna Kalsy

Applicant, print name legibly

1. How do you know this applicant ?
I supervised her clinically from 2008-2012 (roughly)
2. How would you describe the applicant's medical knowledge ?
Sound
3. How would you describe the applicant's clinical technique ?
very good
4. How would you characterize the applicant's relationship with the patients ?
very good
5. How would you the applicant's ability to work with peers and clinical staff ?
very good

MEDICAL BOARD
OCT 14 2014

6. Have you personally known the applicant at least six months? ☒ Yes ☐ No
7. Does the applicant possess good moral character? (If no, explain) ☒ Yes ☐ No
8. Do you recommend this applicant for the professional license being sought? (If no, explain) ☒ Yes ☐ No
9. Are you aware of any information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐ Yes ☒ No



ınal correspondence or information to this form? ☒ Yes ☐ No (employer recommendation form)

Donna Le Burkett 10/6/14

Signature of Recommending Physician (Name stamp not accepted)

128 Lakeside Ave, Ste 301 Burlington, VT 05401

Address (including house number and street, city ,state and zip code

NOTARY

Jane Feustel

Notary Public Signature

2/10/15

Date Commission Expires

Subscribed and Sworn to before me on this 6 day of October ,20 14

JANE FEUSTEL NOTARY PUBLIC STATE OF VERMONT

State Medical Board of Ohio

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

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Sapna Kalsy
Please print applicants first name and last name

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 their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** 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.

Position(s) held: Regional Lead Clinician

Dates of Employment August 30th, 2010 – December 19, 2012

1. How long have you known the applicant? Since Aug 2010
2. What is/was your supervisory capacity? I was her clinical supervisor
3. At what hospital/ clinic? Planned Parenthood Health System
4. How would you rate their medical knowledge and techniques? Sound, excellent, cautious
5. In your opinion is the applicant of good moral and ethical character? Yes
6. Does the applicant work well with peers and medical staff? Yes
7. Does the applicant relate well to patients? Yes
8. How is the applicant's command of the English language (if applicable)? ~~Fe~~ Native language
9. Would you recommend the applicant for licensure? Yes

Additional comments (an additional sheet may be added if needed)

Physician Signature: Donna Burkett 10/6/14

Name of Physician: Donna Burkett

Position: Medical Director

Telephone number (include area code) 802-448-9717 Fax number (include area code) 802-660-9437

E-mail donna.burkett@ppnne.org

MEDICAL BOARD
OCT 14 2014

#134712

State Medical Board of Ohio

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

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.

Sapna Kalsy

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

Sapna Kalsy

Applicant's Printed Last Name

Sapna

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

08/7/14

Date of Signature

Notary Public Signature

03/10/2017

Date Commission Expires

Subscribed and Sworn to before me on this 7TH day of August ,20 14

Somalia Sloane Goldsby
COMM. 2011035
NOTARY PUBLIC CALIFORNIA
LOS ANGELES COUNTY
My Comm. Expires Mar. 10, 2017

MEDICAL BOARD

AUG 29 2014

MEDICAL BOARD OF CALIFORNIA
Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 FAX (916) 263-2944
www.mbc.ca.gov

August 7, 2014

TO WHOM IT MAY CONCERN:

This is to certify that as of August 5, 2014 the records of the Medical Board of California (Board) indicate the following information:

PHYSICIAN:	SAPNA KALSY
LICENSE NUMBER:	A126263
ISSUED:	June 26, 2013
EXAM TYPE:	A Written Examination
EXPIRATION DATE:	August 31, 2016
LICENSE STATUS:	CURRENT
BOARD DISCIPLINE:	No

Further public records pertaining to the above licensee may be available from the Board's Web site at www.mbc.ca.gov.

Curtis J. Worden
Chief of Licensing

Mack, Carolyn

From: verifications@ncmedboard.org
Sent: Thursday, August 07, 2014 01:48 PM
To: Med License
Subject: North Carolina License Verification for Dr. Sapna Kalsy

North Carolina Medical Board

08/07/2014

Name	Sapna Kalsy, MD
Renewal Date	08/28/2015
Public Action	No
Pending Investigation(s)	No

License Number	License Type	Issue Date	Current Status	Expire Date
2008-00417	MD	03/31/2008	Active	
	Resident Training	05/25/2005	Inactive	10/27/2007

Public Actions can be found on our website. Go to www.ncmedboard.org and then select 'Look up a Licensee' under Quick Links.
To receive certified copies of Public Actions, please email legal@ncmedboard.org.
If you have questions regarding Pending Investigation, email don.pittman@ncmedboard.org.

For general Verification questions, email verifications@ncmedboard.org.

Sincerely,

R David Henderson

R. David Henderson
Executive Director

South Carolina
Department of Labor, Licensing and Regulation

Board of Medical Examiners

Nikki R. Haley
Governor

Holly G. Pisarik
Director

110 Centerview Drive
Post Office Box 11289
Columbia, SC 29211-1289
Phone: (803) 896-4500
FAX: (803) 896-4515

License Verification

MEDICAL BOARD
AUG 15 2014

STATE MEDICAL BOARD OF OHIO
30 E BROAD ST 3RD FLOOR
COLUMBUS OH 43215

Name: SAPNA KALSY **Profession:** MD **Office Phone:** NA

Birth Date: 08/28/2011 **Specialty:** PH N

License No: MD 34231 **Date Issued:** 02/22/2012 **Expiration:** 06/30/2015

Basis: US 2007 **School:** DRE **Graduated:** 05/20/2005

Primary Source Verification of Graduation Certified

Hospital Affiliation (s):

Status: ACTIVE

No disciplinary action taken by this Board. This certifies that the above licensee is in good standing.

License History:
Temporary License Number: 34231
Temporary License Issue Date: 11/30/2011
Limited License Number:
Limited License Issue Date:

Verified on 8/13/2014 by: Sheridon Spoon
Sheridon Spoon, Administrator

Unresolved disciplinary actions currently pending before the boards will not be included in the information presented. Reported discipline of licensees indicates the final disposition of contested cases, but may not reflect the current status of a license. Licensees are fully authorized to practice their professions unless their licenses have been restricted, suspended, revoked, deactivated or voluntarily surrendered. Licensees on probation may have been placed under certain professional restrictions which may limit the scope of their practice. Also, board actions reported here may not reflect any subsequent judicial actions to stay or modify the board's decision.

State Medical Board of Ohio

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

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Sapna Kalsx
Please print applicants first name and last name

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 their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** 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.

Position(s) held: contract physician

Dates of Employment 9/13 — 7/14

1. How long have you known the applicant? 1 year
2. What is/was your supervisory capacity? medical director
3. At what hospital/ clinic? Planned Parenthood
4. How would you rate their medical knowledge and techniques? excellent
5. In your opinion is the applicant of good moral and ethical character? yes
6. Does the applicant work well with peers and medical staff? yes
7. Does the applicant relate well to patients? yes
8. How is the applicant's command of the English language (if applicable)? N/A
9. Would you recommend the applicant for licensure? yes

Additional comments (an additional sheet may be added if needed)

Physician Signature: Virginia Siegfried MD

Name of Physician: Virginia Siegfried MD

Position: Medical Director

Telephone number (Include area code) 805 722-5501 Fax number (Include area code)

E-mail ~~vasiegfried@~~ Virginia.siegfried@ppsbvslo.org

9/12

State Medical Board of Ohio

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

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Sapna Kalsy
Please print applicants first name and last name

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 their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** 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.

Position(s) held: contract physician

Dates of Employment 9/13 — 7/14

1. How long have you known the applicant? 1 year
2. What is/was your supervisory capacity? medical director
3. At what hospital/ clinic? Planned Parenthood
4. How would you rate their medical knowledge and techniques? excellent
5. In your opinion is the applicant of good moral and ethical character? yes
6. Does the applicant work well with peers and medical staff? yes
7. Does the applicant relate well to patients? yes
8. How is the applicant's command of the English language (If applicable)? N/A
9. Would you recommend the applicant for licensure? yes

Additional comments (an additional sheet may be added if needed)

Physician Signature: Virginia Siegfried MD

Name of Physician: Virginia Siegfried MD

Position: Medical Director

Telephone number (Include area code) 805 722-5501 Fax number (Include area code)

E-mail ~~vsiegfried@~~
Virginia.siegfried@ppsbvslo.org

August 21, 2014

To Whom It May Concern,

Please accept this explanation in response to the Chronology of Activities October 2007-June 2008.

After two years of Obstetrics and Gynecology training, I gained excellent clinical experience. In the process, I found my true interest in Public Health and General Preventive Medicine.

In October 2007 I made the decision to transfer residencies from Obstetrics and Gynecology to General Preventive Medicine/Public Health. I was accepted to the University of North Carolina's General Preventive Medicine Residency Program beginning July 1, 2008.

In between residencies, I took and passed the USMLE Step 3 examination, applied and was accepted to the University of North Carolina School of Public Health + General Preventive Medicine residency, as well as applied and was approved for medical licensure in the state of North Carolina.

Since my transition to preventive medicine, I have been able to pursue my goal to implement quality measures that improve healthcare provision and access.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Sapna Kalsy, MD, MPH

Sapna Kalsy, MD, MPH

Graduate Medical Education

Institution: **Wake Forest Baptist Medical Center-Wake Forest Uni**
Address: Medical Center Boulevard

Winston Salem, NC 27157
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/24/2005 To 06/22/2006
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/23/2006 To 06/21/2007
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 3
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/22/2007 To 10/28/2007
Completed Successfully: No
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **Yes**
Dates: **09/2007 To 10/2007**
Comments: **Leave of absence 9/28/07-10/28/07 to contemplate career choice.**
Probation: **No**
Disciplined: **No**
Negative Reports: **Yes**
Comments: **Dr. Kalsy misrepresented facts on an assesment of a patient, That was confronted and resolved.**
Limitations: **Yes**
Comments: **Dr.Kalsy's CREOG (inservice exam) score was low resulting in remediation.**

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-4268

Verification of Graduate Medical Education

Institution: Wake Forest University Baptist Health

Address: Department of Obstetrics and Gynecology
Winston Salem, NC 27157

Attention: **Program Director**

Affiliated University: Wake Forest Univerisity

Verification For:

Name: **Kalsy, Sapna**

DOB: **8/28/1977**

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

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (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.

Training Level: 1 (e.g., 1, 2, 3, etc.)
☒Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: OB/GYN
From: 06/24/2005 **To:** 06/22/2006
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: 2 (e.g., 1, 2, 3, etc.)
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: OB/GYN
From: 06/23/2006 **To:** 06/21/2007
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: 3 (e.g., 1, 2, 3, etc.)
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: OB/GYN
From: 06/22/2007 **To:** 10/28/2007
Successfully Completed?: ☐Yes ☒No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐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:

1. Leave of absence 9/28/07-10/28/07 to contemplate career choice.
4. Dr. Kalsy misrepresented facts on an assesment of a patient, That was confronted and resolved.
5. Dr.Kalsy's CREOG (inservice exam) score was low resulting in remediation.

Certification:

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).**

Affix your institutional seal in this space. If no seal is available, you must have this document notarized

Name: Karen R,. Gerancher,MD **Signature:** Karen R. Gerancher,MD

Title of Signatory : Residency Program Director **Date of Signature:** 07/18/2011

Tel: 336-716-4615 Fax: 336-716-6937 E-Mail: kgeranch@wfubmc.edu

ELECTRONIC SEAL VERIFIED

Rev. 09/07/05

FCVS ID:206094 FID: 214710337 FFF CODE [116227]

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: Sapna Kalsy
Wake Forest Baptist Medical Center-Wake Forest Uni
Obstetrics and Gynecology

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**Yes**	No

Dates: 10/2007 to 06/2008
Comments: Transferred to Preventive Medicine residency from Obstetrics and Gynecology residency.

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 by instructors?	**Yes**	No

Comments: I received feedback from an instructor concerning misrepresented facts and assessment of a patient. This issue was resolved at the time this feedback was given.

Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**Yes**	No

Comments: I had no restriction on privileges or limitation in practice. However, a plan of probation and remediation to improve my CREOG (national OB/GYN in-service examination) score and overall performance was discussed. This plan was to be from December 1,

End of report for: Sapna Kalsy

State Medical Board of Ohio

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

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Sapna Kalsey MD
Please print applicants first name and last name

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 their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. The form may also be faxed to the Board at (614) 644-1464. 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.

Position(s) held: Staff physician

Dates of Employment 11/25/13 - 6/30/14

1. How long have you known the applicant? 11/25/13 - 6/30/14
2. What is/was your supervisory capacity? Direct Supervisor
3. At what hospital/ clinic? NECC clinic
4. How would you rate their medical knowledge and techniques? Excellent
5. In your opinion is the applicant of good moral and ethical character? Yes
6. Does the applicant work well with peers and medical staff? Yes
7. Does the applicant relate well to patients? Yes
8. How is the applicant's command of the English language (if applicable)? Yes
9. Would you recommend the applicant for licensure? Yes

Additional comments (an additional sheet may be added if needed) Excellent physician

Physician Signature: [signature] MD

Name of Physician: Christopher Lau MD

Position: Executive Director

Telephone number (include area code) (626) 457-6900 Fax number (include area code)

E-mail clau@necc.net

State Medical Board of Ohio

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

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Sapna Kalsy
Please print applicants first name and last name

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 their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. The form may also be faxed to the Board at (614) 644-1464. 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.

Position(s) held: Independent Contract Physician

Dates of Employment 3/2014 - 7/2014

1. **How long have you known the applicant?** 7 months
2. **What is/was your supervisory capacity?** Medical Director
3. **At what hospital/ clinic?** Planned Parenthood of the Pacific Southwe
4. **How would you rate their medical knowledge and techniques?** excellent
5. **In your opinion is the applicant of good moral and ethical character?** excellent
6. **Does the applicant work well with peers and medical staff?** yes - excellent
7. **Does the applicant relate well to patients?** yes - excellent
8. **How is the applicant's command of the English language (if applicable)?** excellent
9. **Would you recommend the applicant for licensure?** yes

Additional comments (an additional sheet may be added if needed)

Physician Signature: [signature]

Name of Physician: Kelly Caldwell MD MPH

Position: Medical Director

Telephone number (include area code) 619-881-4507 **Fax number (include area code)** 619-297-0959

E-mail Kcaldwell@planned.org

State Medical Board of Ohio

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

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Sapna Kalsey MD
Please print applicants first name and last name

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 their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** 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.

Position(s) held: staff physician

Dates of Employment 11/25/13 - 6/30/14

1. How long have you known the applicant? 11/25/13 - 6/30/14
2. What is/was your supervisory capacity? Direct Supervisor
3. At what hospital/ clinic? NECC Clinic
4. How would you rate their medical knowledge and techniques? Excellent
5. In your opinion is the applicant of good moral and ethical character? Yes
6. Does the applicant work well with peers and medical staff? Yes
7. Does the applicant relate well to patients? Yes
8. How is the applicant's command of the English language (if applicable)? Yes
9. Would you recommend the applicant for licensure? Yes

Additional comments (an additional sheet may be added if needed) Excellent Physician

Physician Signature: _____ MD

Name of Physician: Christopher Lau MD

Position: Executive Director

Telephone number (include area code) (626) 457-6900 Fax number (include area code)

E-mail clau@necc.Net

MEDICAL BOARD

SEP 15 2014

Medical Professional Information Profile

This report provides credentialing information for

Name: **Sapna Kalsy**

Social Security Number: [redacted]

Date of Birth: **August 28, 1977**

FID#: **214710337**

Recipient: **OH - State Medical Board of Ohio**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional 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.

NOTICE: All documents bearing an original Official FCVS seal are certified 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.

This FCVS Medical Professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis Report for further details on the unresolved items

Medical Professional Name: **Sapna Kalsy**
Date of Birth: **August 28, 1977**
Social Security Number: REDACTED
FID: **214710337**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Valid Original Passport OR Copy w/ Cert. of Identification

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

Drexel University College of Medicine
1. Medical Education Form and Translation
2. Medical Education Dean's Letter
3. Medical Education Transcript and Translation
4. Medical Education Diploma and Translation

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

University of North Carolina at Chapel Hill
1. GME Form

Wake Forest Baptist Medical Center-Wake Forest University SOM
1. GME Form

VI. Licensure Examination History

A. FSMB Exam Transcript

End of report for: Sapna Kalsy

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Table of Contents

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Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name: **Sapna Kalsy**
Documentation: Valid Original Passport OR Copy w/ Cert. of Identification

Gender: Female
Date of Birth: August 28, 1977
Place of Birth: CA, UNITED STATES
Social Security Number: REDACTED
FID: 214710337
Physical Description: Height: 5 ft. 5 in.
Weight: 155 lbs.
Eye Color: Brown
Hair Color: Black

Contact Information

Mailing Address: 153 COOPERS HAWK LN
LANDENBERG, PA 19350-9303
UNITED STATES

Permanent Address: 153 COOPERS HAWK LN
LANDENBERG, PA 19350-9303
UNITED STATES

Telephone Numbers: Primary: (336) 655-2544
Secondary: (610) 274-3877
Fax: N/A
Other: N/A

Pre-medical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **Tufts University**
Address: Medford, MA 02144
UNITED STATES
Dates of Attendance: 09/--/1995 To 06/--/1999
Degree Conferred/Issued: Bachelor of Science

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **Drexel University College of Medicine**
Address: Queen Lane Medical Campus
2900 W. Queen Lane
Philadelphia, PA 19129
UNITED STATES

Dates of Attendance: 08/06/2001 to 05/20/2005
Date Certificate Issued: 05/20/2005
Degree Conferred/Issued: Doctor of Medicine

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **Wake Forest Baptist Medical Center-Wake Forest Uni**
Address: Medical Center Boulevard

Winston Salem, NC 27157
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/24/2005 To 06/22/2006
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/23/2006 To 06/21/2007
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 3
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/22/2007 To 10/28/2007
Completed Successfully: No
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **Yes**
Dates: **09/2007 To 10/2007**
Comments: **Leave of absence 9/28/07-10/28/07 to contemplate career choice.**
Probation: **No**
Disciplined: **No**
Negative Reports: **Yes**
Comments: **Dr. Kalsy misrepresented facts on an assesment of a patient, That was confronted and resolved.**
Limitations: **Yes**
Comments: **Dr.Kalsy's CREOG (inservice exam) score was low resulting in remediation.**

Institution: **University of North Carolina at Chapel Hill**
Address: 121 MacNider Building CB# 7240
School of Medicine
Chapel Hill, NC 27599
UNITED STATES

Training Level: 3
Program Type: Residency
Specialty: Preventive Medicine
Dates of Attendance: 07/01/2008 To 06/30/2009
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 4
Program Type: Residency/Chief Residency
Specialty: Preventive Medicine
Dates of Attendance: 07/01/2009 To 06/30/2010
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Licensure Examinations

FSMB Transcript USMLE Step 1	Date: 06/2003	Passed the Exam
FSMB Transcript USMLE Step 2 CK	Date: 01/2005	Passed the Exam
FSMB Transcript USMLE Step 2 CS	Date: 04/2005	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 12/2007	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

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

End of report for: Sapna Kalsy FID: 214710337

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

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

Medical Professional Identification

Medical Professional Name:	**Sapna Kalsy**
Date of Birth:	**August 28, 1977**
Social Security Number:	REDACTED
FID:	**214710337**

Omissions

There are no omissions identified.

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Discrepancies

There are no discrepancies identified.

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Sapna Kalsy

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Sapna Kalsy**
Date of Birth: **August 28, 1977**
Social Security Number: REDACTE
FID#: **214710337**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
07/2001	05/2005	Medical Education Record	Drexel University College of Medicine,Queen Lane Medical Campus Philadelphia, PA 19129 UNITED STATES		
06/2005	10/2007	GME Record	Wake Forest Baptist Medical Center-Wake Forest Uni,Medical Center Boulevard Winston Salem, NC 27157 UNITED STATES		
11/2007	06/2008	Seeking a GME Program			
07/2008	06/2010	GME Record	University of North Carolina at Chapel Hill,121 MacNider Building CB# 7240 Chapel Hill, NC 27599 UNITED STATES		

End of report for: Sapna Kalsy

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Section II

FSMB and Other Reports

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PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:8/25/2014

PRACTITIONER INFORMATION

Name:	Sapna Kalsy
DOB:	8/28/1977
Medical School:	Drexel University College of Medicine Philadelphia, Pennsylvania, UNITED STATES
Year of Grad:	2005
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Reported
CALIFORNIA	A-126263	6/26/2013	8/31/2014	10/22/2013
NORTH CAROLINA		5/25/2005	10/27/2007	8/5/2014
NORTH CAROLINA	2008-00417	3/31/2008	8/28/2015	8/5/2014
SOUTH CAROLINA	34231	2/22/2012	6/30/2015	8/4/2014

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As of:	**08/25/2014**
Medical Professional Name:	**Sapna Kalsy**
Date of Birth:	**8/28/1977**
Year of Graduation:	**2005 (Doctor of Medicine)**
ABMSUID#:	**1009141**

Certification

Certification:

Board:	Preventive Medicine
Specialty:	Public Health and General Preventive Medicine
Status:	IACT
Initial Certification:	01/01/2013

End of report for Sapna Kalsy

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

Section III

Identity

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, 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 me 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I, hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

VICTOR BRAGMAN NOTARY PUBLIC FORSYTH COUNTY, NC

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

Kalsy Sapna

Applicant's Printed Last Name

6/8/2011

Date of Signature (must correspond to date of notarization)

State of NORTH CAROLINA, County of FORSYTH,
I certify that on the date set forth below 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. The statements on this document are subscribed and sworn to before me by the applicant on this 8th day of June, 2011.

VICTOR BRAGMAN NOTARY PUBLIC FORSYTH COUNTY, NC

Notary Public Signature:

My Notary Commission Expires: 2-13-12

206094 214710337

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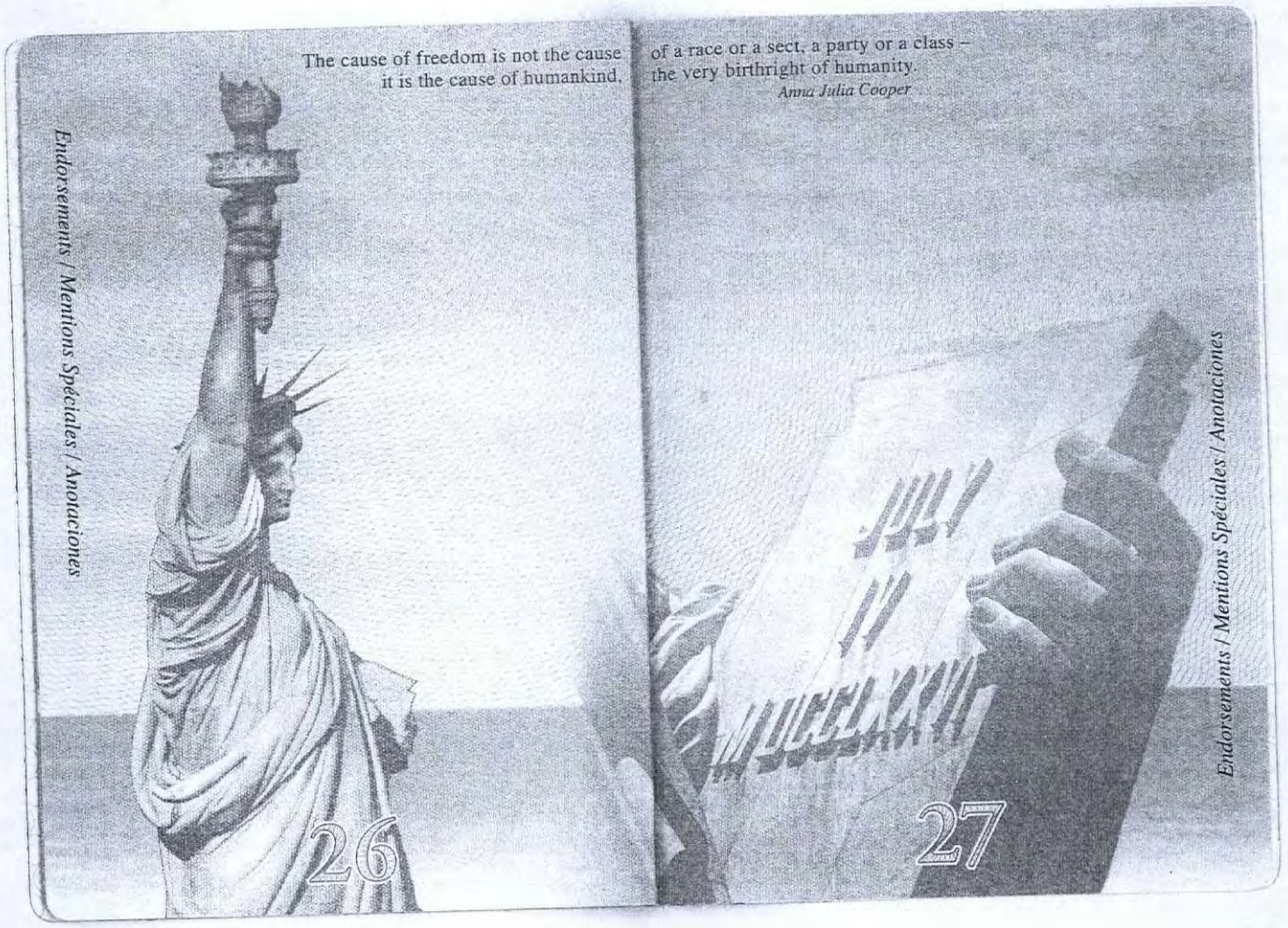
Kevin Caldwell
Federation Credentials Verification Service

June 15, 2011
Date

206094



THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES
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Kevin Caldwell
Federation Credentials Verification Service

June 15, 2011

Date

2060 94

Section IV

Medical Education

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

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 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).

RECEIVED 2011 NOV 17 PM 1:09 UNIVERSITY REGISTRAR QUEEN LANE CAMPUS

Institution Name: Drexel University College of Medicine

Address Line 1:
2900 Queen Lane

Address Line 2:
Suite G27

City: Philadelphia **State/Province:** PA **Zip Code (Postal Code):** 19129
Country: US

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

Premedical Education:
Years of education required for admission to your medical school: 4
Credential/degree presented by the applicant for admission to your medical school: BACHELOR OF SCIENCE

Enrollment and Participation: Our records indicate that Sapna Kalsy
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 160 weeks of medical education on the following dates: **From:** 8/16/01 (Month Day Year) **To:** 5/20/05 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 5/20/05 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If available, this form must be notarized.

Watermark
For FCVS internal use only.

Name: Amy L. Nickerson
Signature: Academic Records Coordinator
Title:

Date of Signature: 11/17/11 **Phone:** (215) 991-8207
Fax: (215) 843-5243 **Email:** aln53@drexel.edu

ELECTRONIC SEAL VERIFIED 206094

335 214710337

Unusual Circumstances

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

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the Interruption/extension was approved or unapproved:

Personal/Family	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Academic remediation	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Health	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Financial	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in joint degree Program (e.g., MD/PhD)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-degree research	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Other	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved

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? ___ YES ✓ NO

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

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

Please specify a 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? ___ YES ✓ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? ___ YES ✓ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

___ YES ✓ NO

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?

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

206094 4098 335 214710337

Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Sapna Kalsy

Drexel University College of Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in 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 by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: Sapna Kalsy

PROVIDED BY APPLICANT

Drexel University College of Medicine
In the tradition of Woman's Medical College of Pennsylvania and Hahnemann Medical College

Office of Student Affairs

Medical Student Performance Evaluation for
Sapna Kalsy
November 1, 2004

Identifying Information

This is an evaluation of Sapna Kalsy, a candidate for a residency position in your program. She is currently a student in the final year of the curriculum at Drexel University College of Medicine in Philadelphia, Pennsylvania, and is expected to receive the M.D. degree on May 20, 2005.

Unique Characteristics

Sapna Kalsy received a Bachelor of Science degree in Biology from Tufts University in May 1999. As an undergraduate, Sapna served as a Research Assistant in Pharmacology and in the Department of Psychology. She also served as an Assistant in the Department of Art History. Following the completion of undergraduate study, Sapna was employed at New England Medical Center in the Department of Psychiatry as a Research Assistant.

Since matriculating to Drexel University College of Medicine, Sapna has been active in the South Asian Medical Student Association and the Wilderness Club. She also attended the American College of Obstetrics and Gynecology annual meetings. Sapna enjoys travel, voice training, drawing and oil painting, swimming, water polo, kayaking and camping.

Academic History

Date of Expected Graduation from Medical School	May 2005
Date of Initial Matriculation in Medical School	August 2001

Extensions, Leave(s) of Absence, Gaps, or Breaks in Student's educational program: None

Was this student required to repeat or remediate any coursework during his/her medical education? No

Sapna Kalsy has not been the recipient of any adverse action by the medical school or its parent institution.

Academic Progress

Preclinical Record

Sapna Kalsy matriculated to Drexel University College of Medicine in August 2001, enrolling in the Program for Integrated Learning curricular track. The Program for Integrated Learning is a problem based, student driven curriculum composed of seven Blocks, each containing core basic science and clinical science learning objectives. Students participate in facilitated small group and laboratory exercises and earn grades for completed Blocks, rather than for individual courses.

Sapna successfully completed the Program for Integrated Learning and earned a score of 204 on Step 1 of the USMLE.

Clinical Clerkship Record

Family Medicine

Clinical Performance Grade: 4.25/5.0 **Final Transcript Grade: Highly Satisfactory**

Everyone at Saint Vincent's was impressed with Student Doctor Kalsy. This was her first clinical rotation and her growth in this short six-week rotation was most impressive. Her ability to work with other students, residents and faculty was superb. Her communication skills both written and with patients was exceptional. I think this student is off to an excellent start as a third year student and as a professional.

Pediatrics

Clinical Performance Grade: 4.0/5.0 **Final Transcript Grade: Highly Satisfactory**

Self-motivated, good history taking skills. Enthusiastic, good case presentation, pleasant, interested in learning.

Surgery

Final Transcript Grade: Highly Satisfactory

The following comments were taken from evaluations of various faculty members and residents: Sapna is a hard working, energetic and dependable student who demonstrated much initiative during the Surgery Clerkship. She asked good questions, her participation at lectures was excellent. Sapna was reliable and came well prepared. She helped house staff in the retrieval of patient information and was compassionate toward her patients. Her interaction with the parents and children at St. Christopher's Hospital for Children was superb. Sapna's performance on the trauma service was superior. She presented good organized cases, demonstrated very good clinical problem solving skills and performed very well on her oral exams. Sapna was a pleasure to have on service.

Psychiatry

Clinical Performance Grade: 5.0/5.0 **Final Transcript Grade: Satisfactory**

Sapna will be an excellent physician. Besides the knowledge and skill, she has the human qualities that the best physicians have.

Obstetrics & Gynecology

Clinical Performance Grade: 4.0/5.0 **Final Transcript Grade: Highly Satisfactory**

Sapna did an excellent job during her Ob/Gyn rotation achieving a final grade of above expected. She is a very enthusiastic, knowledgeable and hard working student. She has a pleasant, witty personality and was an enjoyable asset to the team. She will be an excellent house officer.

Medicine

Clinical Performance Grade: 3.9/5.0 **Final Transcript Grade: Satisfactory**

Sapna did a good job on the medicine clerkship. She possesses a fund of knowledge at an expected level for her level of training. Her history taking and physical examination skills are quite good and at an above expected level as are her clinical reasoning and data synthesis skills. Sapna was found to be very pleasant to work with and demonstrated growth in knowledge over the course of the rotation. She was very enthusiastic about her assignments. She was helpful to all members of the patient care team and was able to develop an excellent rapport with patients. Sapna's strengths are in her professionalism. She is self-motivated and committed to incorporating feedback to improve her overall performance.

In the ambulatory setting, Sapna performed in an outstanding manner. Her strengths include her professional work habits, commitment to learning, history taking, communication and clinical reasoning skills. Her small group and learning issue investigation showed a strong ability to arrive at hypotheses and an in-depth review and understanding of the material.

Fourth Year Courses

Ob/Gyn Sub-I in a Community Hospital **Final Transcript Grade: Honors**

Sapna is a highly motivated and energetic team player. She is bright, focused and pleasant and has superb communication skills. She is the model of professionalism and will be an enormous asset to any field of medicine she chooses. She needs only to stay steady in her course.

Gynecology Oncology, Wake Forest University, NC

Final Transcript Grade: Honors

A+ for professionalism – performed clinical duties always above level expected. Very professional behavior.

Clinical Skills Assessment

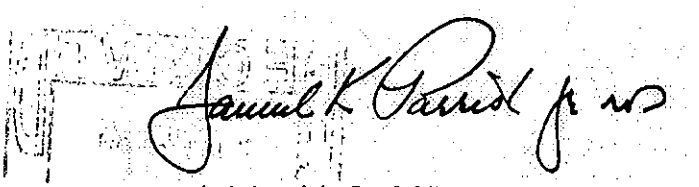
All students at Drexel University College of Medicine participate in a 10 stage OSCE Clinical Skills Assessment upon completion of the third year clinical clerkships. Sapna Kalsy successfully completed this requirement for graduation.

Professionalism

Sapna Kalsy has demonstrated honesty, respect, integrity and a commitment to self-assessment, self-improvement and lifelong learning. Sapna has earned high marks for professionalism throughout her medical school career.

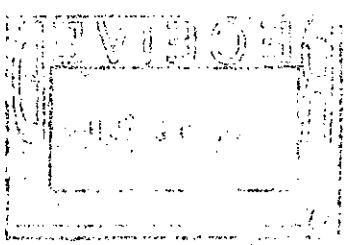
Summary

Sapna Kalsy has received consistent and enthusiastic evaluations from her clinical clerkship experiences. Sapna is an excellent student with sound judgment and decision-making abilities. She has a strong knowledge base and applies basic science principles to clinical problems. She is always prepared and can be depended on to follow through. Sapna is technically proficient and maintains her composure in difficult situations. She is meticulous in her approach to patient evaluation and differential diagnosis. Sapna utilizes resources and consultation appropriately. She is a talented and capable individual who clearly enjoys the learning process and contributes to the learning of others. Sapna is professional in all interactions with patients, families and coworkers. She is respected by faculty and her classmates as an excellent clinician and as a model for professionalism. Sapna Kalsy has clearly demonstrated the academic, clinical and professional attributes that will ensure her success in the most demanding residency program. Sapna will undoubtedly become a valued house officer and a capable and productive clinician. On behalf of the faculty and administration of Drexel University College of Medicine, I am pleased to provide this Medical Student Performance Evaluation of Sapna Kalsy, who is applying for a residency position in your program.

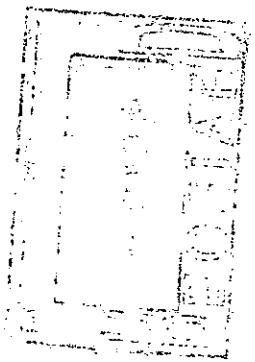


Samuel K. Parrish, Jr., M.D.

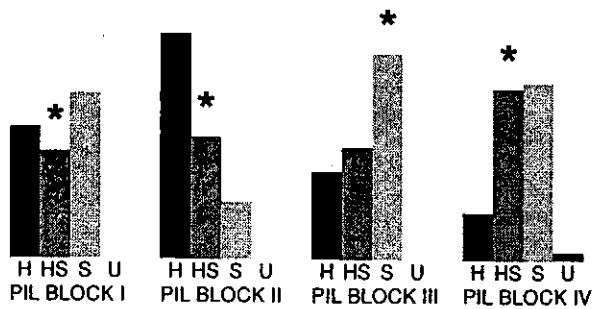
Associate Professor of Pediatrics
Associate Dean of Student Affairs
215.991.8222
skp25@drexel.edu



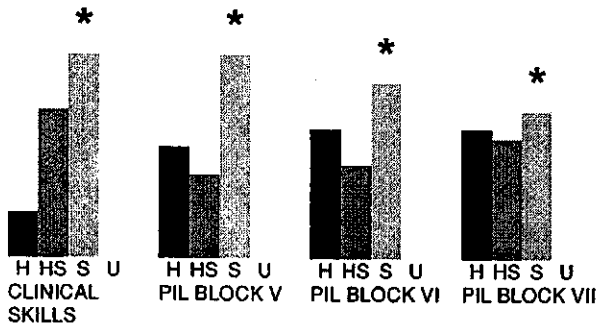
Sapna Kalsy



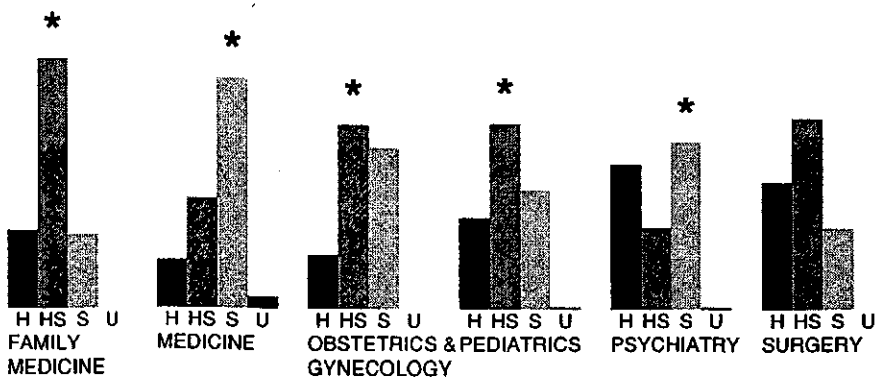
YEAR ONE



YEAR TWO



YEAR THREE



KEY: **H: HONORS** **HS: HIGHLY SATISFACTORY** **S: SATISFACTORY** **U: UNSATISFACTORY**

Drexel University College of Medicine

In the tradition of Woman's Medical College of Pennsylvania and Hahnemann Medical College

Office of Student Affairs

Preface to the Medical Student Performance Evaluation

Dear Program Director: November 1, 2004

Drexel University College of Medicine uses grades of **HONORS, HIGHLY SATISFACTORY, SATISFACTORY and UNSATISFACTORY.**

Rotations two weeks in duration are graded as SATISFACTORY/UNSATISFACTORY only.

We do not rank our students.

Students at Drexel University College of Medicine may choose one of two curriculum tracks in the preclinical years: The Program for Integrated Learning- a Problem-based curricular track, which uses facilitated small group format with laboratories, or the Interdepartmental Foundations of Medicine curricular track. The IFM curricular track is organized by system and symptoms, and is predominately lecture and laboratory based in its structure.

The Medical School Performance Evaluation provides program directors with the following information:

1. The Medical School Performance Evaluation includes the student's background information; a summary of academic performance during the preclinical years; clinical performance in the third year clerkships (in chronological order) with course director summary comments and/or faculty members' narrative comments and summative concluding remarks.

2. A graphic representation of class performance with individual student performance indicated for Years 1 through 3.

Please contact me if I can be of further assistance in your evaluation of our students.

Yours truly,

Samuel K. Parrish, Jr., M.D.
Associate Dean for Student Affairs
Associate Professor of Pediatrics
Drexel University College of Medicine
215-991-8222 skp25@drexel.edu

2900 Queen Lane, Philadelphia, PA 19129-1096 ▪ TEL 215.991.8223 FAX 215.843.1766
www.drexel.edu/med

Appendices C, D & E

Appendix C: Professionalism- Graphic representation of Student Performance

Professionalism is evaluated as an academic component of each clerkship grade and is reported in the narrative evaluation of each clerkship. A separate graphic representation and comparison is not calculated for individual students.

Appendix D: Graphic Presentation of Student Performance in Comparison to Class

Drexel University College of Medicine does not rank its students.

Appendix E: Medical School Information

Drexel University College of Medicine

Philadelphia, Pennsylvania

Special characteristics of the medical school's educational programs:
Drexel University college of Medicine offers two distinct educational programs for the initial two years of medical school. The **Interdisciplinary Foundations of Medicine** curricular track is a lecture and laboratory based educational curriculum in which core basic science material is presented in an integrated fashion within a clinical framework. During the first year of medical school, a symptom based format is utilized to integrate core basic science concepts and during the second medical school year, a systems based format is utilized to proved integration of basic science content within the curriculum. Approximately 180-200 students participate in the IFM curriculum in each entering class.

The **Program for Integrated Learning** is a student driven, facilitated small group curriculum in which students complete seven Blocks, each containing core basic science and clinical science learning objectives. Students apply for admission to the PIL program following admission to medical school. Students utilize clinical cases to identify learning objectives and are evaluated through written examinations and individual process assessments. Approximately 40-50 students participate in the PIL curriculum in each entering class.

Average length of enrollment at the medical school:
4 years

Description of the evaluation system used at the medical school:
USMLE Step 1 – required for promotion to the Third Medical School Year

USMLE Step 2 – required for graduation

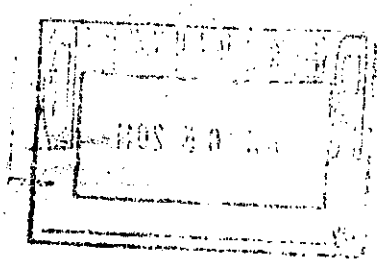
Medical School requirements for successful completion of Observed Structured Clinical Evaluation at medical school: OSCEs are used for:
Completion of course:

PIL Curriculum-Block IV
Introduction to Clinical Medicine-Year 2, IFM curriculum
Graduation requirement:
Year 3-clinical Skills Assessment-required of all students for graduation

Utilization of the course, clerkship or elective director's narrative comments in the composition of the MSPE:
The narrative comments contained in the attached MSPE can be best described as reported exactly as written.

Utilization by the medical school of the AAMC Guidelines for Medical Schools Regarding Academic Transcripts.
This medical school is completely in compliance with Guidelines' recommendations.

Description of the process by which the MSPE is composed at the medical school. Students are permitted to review the MSPE prior to its transmission for accuracy of information only.



DREXEL UNIVERSITY - Office of the University Registrar

QUEEN LANE MEDICAL CAMPUS • 2900 QUEEN LANE • SUITE G-24 • PHILADELPHIA, PA 19129

Student No: 60031644

Date Issued: 01-JUL-2011
CoM Official Transcript, MD

Record of: Sapna Kalsy
Current Name: Sapna Kalsy
Apt 2F
1628 Spruce St
Philadelphia, PA 19103

Issued To: FCVS

Course Level: Medicine
Only Admit: Fall Semester 01-02

Current Program
Doctor of Medicine
College : College of Medicine
Major : Medicine

Degrees Awarded Doctor of Medicine 20-MAY-2005
Major : Medicine

SUBJ	NO.	COURSE TITLE	GRD	R
INSTITUTION CREDIT:				
Term:		Fall Semester 01-02		
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR	-	
PILM	710S	PIL BLOCK I	HS	
PILM	711S	FOCUS GROSS ANATOMY	+	
PILM	712S	HISTOLOGY	+	
PILM	713S	INTRO TO THE PATIENT	+	
PILM	720S	PIL BLOCK II	HS	
PILM	721S	NEUROSCIENCE	+	
PILM	722S	PHYSIOLOGY	+	
PILM	723S	INTRO TO THE PATIENT	+	
		Total Earned Credits 1.00		
Good Standing				
Term:		Spring Semester 01-02		
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR	-	
PILM	730S	PIL BLOCK III	S	
PILM	731S	MICROBIOLOGY & IMMUNOLOGY	+	
PILM	732S	BIOCHEMISTRY	+	
PILM	733S	INTRO TO THE PATIENT	+	
		Total Earned Credits 1.00		
Good Standing				

********** CONTINUED ON NEXT COLUMN **********

SUBJ	NO.	COURSE TITLE	GRD	R
Institution Information continued:				
Term:		Summer Semester 01-02		
College of Medicine				
Medicine				
PILM	740S	PIL BLOCK IV	HS	
PILM	741S	PRIMARY CARE PRACTICUM	+	
		Total Earned Credits 0.00		
Good Standing				
Term:		Fall Semester 02-03		
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR	-	
PILM	750S	PIL BLOCK V	S	
PILM	751S	FOUNDATION BASIC SCIENCE	+	
PILM	752S	PATHOLOGY	+	
PILM	753S	PATHOPHYSIOLOGY	+	
PILM	754S	PHARMACOLOGY	+	
PILM	756S	INTRO TO THE PATIENT	+	
PILM	757S	COMM CONTINUITY PRACTICUM	+	
PILM	758S	PSYCHOPATHOLOGY	+	
PILM	760S	PIL BLOCK VI	S	
PILM	761S	FOUNDATION BASIC SCIENCE	+	
PILM	762S	PATHOLOGY	+	
PILM	763S	PATHOPHYSIOLOGY	+	
PILM	764S	PHARMACOLOGY	+	
PILM	765S	PSYCHIATRY	+	
PILM	766S	INTRO TO THE PATIENT	+	
PILM	767S	COMM CONTINUITY PRACTICUM	+	
		Total Earned Credits 1.00		
Good Standing				
Term:		Spring Semester 02-03		
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR	-	
PILM	770S	PIL BLOCK VII	S	
PILM	771S	FOUNDATION BASIC SCIENCE	+	
PILM	772S	PATHOLOGY	+	

********** CONTINUED ON PAGE 2 **********

SEAL VERIFIED

20094 335

AN OFFICIAL SIGNATURE IS WHITE WITH A BLUE BACKGROUND • REJECT DOCUMENT IF SIGNATURE BELOW IS DISTORTED

A black and white transcript is NOT an original • void appears if copied

Joseph J. Salomone

Joseph J. Salomone, University Registrar

This officially sealed and signed transcript is printed on blue safety background. Stains indicate unauthorized alterations. When copied void will appear. A BLACK ON WHITE OR COLOR COPY SHOULD NOT BE ACCEPTED.

NOTE: The column after GRD and PTS labeled R refers to whether or not certain repeatable courses are included (I) in the student's GPA. An (I) shown in this column indicates that the grade shown in the GRD column is included in the student's grade point average.

SUBJ	NO.	COURSE TITLE	GRD	R
Institution Information continued:				
PILM	773S	PATHOPHYSIOLOGY	+	
PILM	774S	PHARMACOLOGY	+	
PILM	775S	PSYCHIATRY	+	
PILM	776S	INTRO TO THE PATIENT	+	
PILM	777S	COMM CONTINUITY PRACTICUM	+	
PILM	778S	CLINICAL SKILLS	S	
		Total Earned Credits 1.00		
Good Standing				
Term: Fall Semester 03-04				
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR	-	
FAMD	8010S	FAMILY MEDICINE	HS	
PEDS	8010S	PEDIATRICS	HS	
SURG	8010S	SURGERY	HS	
		Total Earned Credits 1.00		
Good Standing				
Term: Spring Semester 03-04				
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR	-	
MEDI	8010S	MEDICINE	S	
OBGY	8010S	OBSTETRICS & GYNECOLOGY	HS	
PSYC	8010S	PSYCHIATRY	S	
		Total Earned Credits 1.00		
Good Standing				
Term: Fall Semester 04-05				
OBGY-9093, Gynecology Oncology, 3WKS., taken @ Wake Forest University SOM, NC.				
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR	-	
MEDI	8504S	MEDICINE SUBINTERNSHIP	HS	
NEUL	8014S	NEUROLOGY	HS	
OBGY	8214S	OB/GYN SUBINTERNSHIP	H	

********** CONTINUED ON NEXT COLUMN **********

SUBJ	NO.	COURSE TITLE	GRD	R
Institution Information continued:				
OBGY	9093S	ELECTIVE-OB/GYN- 3WKS.	H	
		Total Earned Credits 1.00		
Good Standing				
Term: Spring Semester 04-05				
College of Medicine				
Medicine				
0000	800S	REGISTRATION INDICATOR	-	
ANAT	8112S	ANATOMY - 2 WEEKS (S/U)	S	
ANES	8212S	CLINICAL ANESTHESIOLOGY-2WKS	S	
DERM	8114S	CLINICAL DERMATOLOGY	HS	
PATH	8314S	ANATOMIC PATH & LAB MEDICINE	HS	
PEDS	9114S	PED HIV & OTHER IMMUN DISORDER	S	
RADI	9312S	PEDIATRIC RADIOLOGY - 2 WEEKS	S	
RADI	9314S	PEDIATRIC RADIOLOGY	S	
		Total Earned Credits 1.00		
Good Standing				

********** END OF TRANSCRIPT **********

206094 335

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DREXEL UNIVERSITY COLLEGE OF MEDICINE TRANSCRIPT

Office of the University Registrar
Queen Lane Medical Campus
2900 Queen Lane
Suite G-24
Philadelphia, PA 19129
(215) 991-8206

Office of the University Registrar
Center City Hahnemann Campus
245 N. 15th Street
MS 445
Philadelphia, PA 19102
(215) 762-7602

Office of the University Registrar
University City Main Campus
3141 Chestnut Street
Curtis 261
Philadelphia, PA 19104
(215) 895-1439

EXPLANATION OF TRANSCRIPT

Drexel University College of Medicine, previously MCP Hahnemann University School of Medicine prior to July 1, 2002 was known as Allegheny University of the Health Sciences prior to November 10, 1998; also known as MCP Hahnemann School of Medicine until June 20, 1996, which was formed in 1993 by the Medical College of Pennsylvania (MCP) (formerly Women's Medical College of Pennsylvania prior to May 8, 1970) and Hahnemann University (formerly Hahnemann Medical College prior to August 20, 1982).

ACCREDITATION

Drexel University is accredited by the Middle States Commission on Higher Education. The M.D. degree is accredited by the Liaison Committee on Medical Education.

TRANSCRIPT FORMAT

This officially sealed transcript is printed on light blue security paper and signed by the University Registrar. A raised seal or tricolor stamp is not used nor is it required. When photocopied, the word void will appear. A black and white document is not an original and should not be accepted as an official institutional document. On occasion an official transcript will be issued to a student in a sealed envelope. In such cases, this fact is indicated on the envelope as well as on the face of the transcript. The student is identified by an eight-digit numeric ID number that is followed by the student's program of study. Any degrees awarded are so identified and appear in the upper left area of the first page of the transcript. Changes of major appear at appropriate terms throughout the body of the transcript.

UNIT OF CREDIT

One credit hour represents one contact hour of recitation/lecture, or two to three contact hours of laboratory per week for a full term. The Drexel University College of Medicine grants the professional degree Doctor of Medicine as well as Master and Doctoral (Ph.D.) degrees and certificates. The College of Medicine does not assign credit hours to courses taken to satisfy the requirements for the Doctor of Medicine degree, but does for certificate and Master and Doctoral level courses.

EXPLANATION OF GRADES AND GRADE POINTS

Standard Grade	Quality Points Before Fall 2006	Quality Points Beginning Fall 2006
A+	4.30 points	4.00 points
A	4.00 points	4.00 points
A-	3.70 points	3.67 points
B+	3.30 points	3.33 points
B	3.00 points	3.00 points
B-	2.70 points	2.67 points
C+	2.30 points	2.33 points
C	2.00 points	2.00 points
C-	1.70 points	1.67 points
D+	1.30 points	discontinued
D	1.00 points	1.00 points
D-	0.70 points	discontinued
F	0.00 points	0.00 points

Other Grades	
+	Courses within a Block
-	Registration Indicator
AU	Audit
EX	Exemption (course previously taken)
H	Honors
HP	High Pass.....discontinued Fall 1992
HS	Highly Satisfactory
P	Pass.....discontinued Fall 2000
S	Satisfactory
T	Transfer Credit
U	Unsatisfactory
W	Withdrawn
WF	Withdrawn Failing
WP	Withdrawn Passing

Temporary Grades

I	Incomplete
IP	In Progress
NGR	No Grade Reported
NR	No Grade Reported

EXPLANATION OF REPEATED COURSES

Courses with an indicator of "I" in the R column of the transcript will be included in the term and cumulative credits earned and GPAs; courses with an "E" in the R column will be excluded from the term and cumulative GPAs but retained in term and cumulative credits attempted; courses with an "A" in the R column will be excluded from the term and cumulative credits earned, but retained in term and cumulative credits attempted and calculated in the term and cumulative GPAs.

Universitas Drexelis

Collegium Medicinae

OMNIBUS HAS LITTERAS PRAESENTES LECTURIS

SALUTEM

Cum Academiae ubique gentium institutae Philosophia Scientiis Medicina Litterisque Humanis excultos aut de Republica bene meritos titulo justo et congruente condecorare solitae sint. Nos igitur Professores Curatoresque Universitatis Drexelis Philadelphiae auctoritate reipublicae Pennsylvaniensis nobis commissa

Sapna Kalsy

bona indole praeditum omnibus muneribus atque officiis quae hujus Academiae legibus ei imposita sunt constanter et fideliter expletis ad gradum

Medicinae Doctoris

rite admisimus eique omnia jura honores privilegia ad hunc gradum pertinentia libenter concessimus.

Cujus rei testimonio nomina nostra hoc die XX Mensis Maii Anno Domini MMV Philadelphiae subscripsimus et quo major sit fides auctoritasque Curatores consentientes Academiae nostrae sigilla apponi jusserunt.

DREXEL UNIVERSITY SCIENCE INDUSTRY ART 1891

Decanus

Vicecomes Curatorum

DREXEL UNIVERSITY COLLEGE OF MEDICINE

Praeses

2060094 335

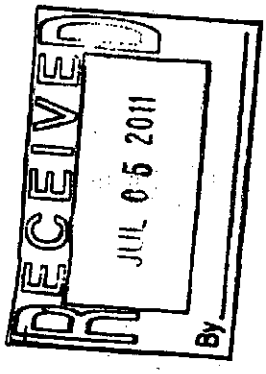
SEAL VERIFIED

"Certified to be a true copy of the M.D. diploma of:"

Sapna Kalsy

University Registrar
Drexel University

Joseph Salomone, University Registrar
July 1, 2011



Drexel
UNIVERSITY

Office of the University Registrar Queen Lane Medical Campus

Official Translation of the Diploma of Drexel University

COLLEGE OF MEDICINE

To All Whom These Presents May Come

Greetings

Whereas it is customary for Universities all the world to acknowledge the proficiency of students in Philosophy, the Sciences, Medicine and Humanities by the awarding of the proper and fitting degrees,

Therefore, we, the Board of Trustees at Drexel University, by the authority vested in us by the Commonwealth of Pennsylvania, do hereby award

Sapna Kalsy

the degree of
Doctor of Medicine

having demonstrated his/her ability and conscientiously and faithfully fulfilled all of the duties and requirements of this University,

And we grant him/her all of the rights, honors and privileges thereunto appertaining.

In witness whereof, this diploma is issued and signed by us in Philadelphia, on **May 20, 2005** and the Board of Trustees ordered that the College seal be affixed in witness of our full faith and authority.

University Registrar
Drexel University

Joseph J. Salomone, University Registrar
July 1, 2011

SEAL
VERIFIED

2900 Queen Lane, Suite G-27 • Philadelphia, PA 19129 • **TEL** 215.991.8206 • **FAX** 215.843.5243 • **E-MAIL** QLcert@drexel.edu • **www.drexel.edu**

206094 335

Section V

Graduate Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-4268

Verification of Graduate Medical Education

Institution: Wake Forest University Baptist Health

Address: Department of Obstetrics and Gynecology
Winston Salem, NC 27157

Attention: **Program Director**

Affiliated University: Wake Forest Univerisity

Verification For:

Name: **Kalsy, Sapna**

DOB: **8/28/1977**

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

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected comple ion 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.

Training Level: 1 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: OB/GYN
From: 06/24/2005 **To:** 06/22/2006
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: 2 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: OB/GYN
From: 06/23/2006 **To:** 06/21/2007
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: 3 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: OB/GYN
From: 06/22/2007 **To:** 10/28/2007
Successfully Completed?: ☐ Yes ☒ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ 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:

1. Leave of absence 9/28/07-10/28/07 to contemplate career choice.
4. Dr. Kalsy misrepresented facts on an assesment of a patient. That was confronted and resolved.
5. Dr.Kalsy's CREOG (inservice exam) score was low resulting in remediation.

Certification:

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).**

Affix your institutional seal in this space. If no seal is available, you must have this certified

Name: Karen R,. Gerancher,MD

Signature: Karen R. Gerancher,MD

Title of Signatory: Residency Program Director

Date of Signature: 07/18/2011

Tel: 336-716-4615 Fax: 336-716-6937 E-Mail: kgeranch@wfubmc.edu

ELECTRONIC SEAL VERIFIED

Graduate Medical Education

Medical Professional Name: Sapna Kalsy

Wake Forest Baptist Medical Center-Wake Forest Uni

Obstetrics and Gynecology

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**Yes**	No

Dates: 10/2007 to 06/2008

Comments: Transferred to Preventive Medicine residency from Obstetrics and Gynecology residency.

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 by instructors?	**Yes**	No

Comments: I received feedback from an instructor concerning misrepresented facts and assessment of a patient. This issue was resolved at the time this feedback was given.

Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**Yes**	No

Comments: I had no restriction on privileges or limitation in practice. However, a plan of probation and remediation to improve my CREOG (national OB/GYN in-service examination) score and overall performance was discussed. This plan was to be from December 1,

End of report for: Sapna Kalsy

Applicant Reported Unusual Circumstances

PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 **TEL**(817)868-5000 **FAX**(817)868-5099

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-4268

Verification of Graduate Medical Education

Institution: University of North Carolina at Chapel Hill

Address: Department of Preventative Medicine

Chapel Hill, NC 27599

Attention: **Program Director**

Affiliated University: ____

Verification For:

Name: **Kalsy, Sapna**

DOB: **8/28/1977**

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

RECEIVED
JAN 28 2013

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (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.

Training Level: 3 (e.g., 1, 2, 3, etc.)
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: Preventive Medicine

From: 07/01/2008 To: 06/30/2009

Successfully Completed?: ☒Yes ☐No ☐In Progress

Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: 4 (e.g., 1, 2, 3, etc.)
☐Internship ☒Residency ☒Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: Preventive Medicine

From: 07/01/2009 To: 06/30/2010

Successfully Completed?: ☒Yes ☐No ☐In Progress

Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: ____ (e.g., 1, 2, 3, etc.)
☐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 ☐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.

SEAL VERIFIED

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:

____

____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

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: Deborah Porterfield, MD MPH

Signature: [signature]

Title of Signatory: Program Director

Date of Signature: 08/22/11

Tel: 919-843-8267 Fax: 919-843-1201 E-Mail: dport@med.unc.edu

Graduate Medical Education

Medical Professional Name: Sapna Kalsy
University of North Carolina at Chapel Hill
Preventive Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in 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 by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: Sapna Kalsy

PROVIDED BY APPLICANT

Section VI

Licensure Examination History

(State Licensing Authorities Only)

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

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, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date : **08/22/2014**

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 206094

Examinee: Kalsy, Sapna
Alt Name(s):

Examinee ID#: 5-119-632-7
Date of Birth: 08/28/1977

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, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	06/19/2003	Pass	204	(182)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	01/26/2005	Pass	193	(182)	

Clinical Skills (CS)*

	Test Date	Pass/Fail	Total	MP	Comments
	04/05/2005	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
NORTH CAROLINA	12/10/2007	Pass	196	(184)	

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Examinee: Kalsy, Sapna

Examinee ID#: 5-119-632-7
Date of Birth: 08/28/1977

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. **No score is reported.** Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

4/2013

State Medical Board of Ohio

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

10/15/2014

Sapna Kalsy, MD
153 Cooper's Hawk Lane
Landenberg PA 19350

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **125166** was issued on **10/15/2014** and will expire on **10/01/2016**.

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

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

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

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

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

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

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

Sincerely,

Mitchell Alderson
Chief, Licensure

Date Posted: 9/15/2016 9:38:39 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	2314 Auburn Avenue Cincinnati, OH 45219 Hamilton County United States (513) 721-7635 jnoel@ppswo.org
CREDENTIAL MAIL ADDRESS	2314 Auburn Avenue Cincinnati, OH 45219 Hamilton County United States (513) 721-7635 jnoel@ppswo.org
CREDENTIAL MAIL ADDRESS	2314 Auburn Avenue Cincinnati, OH 45219 Hamilton County United States (513) 721-7635 jnoel@ppswo.org
MAIN	903 Adams Crossing Unit 102 Cincinnati, OH 45202 Hamilton County United States (513) 721-7635 jnoel@ppswo.org

License Information

License Number	35.125166
License Name	Sapna Kalsy

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

. . . . . PUBLIC HEALTH & GEN PREVENTIVE MED

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. **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.**

. . . . . Melinda Chimento, CNP; Jessica Cooper, CNP; Tracy Dillingham, CNP; Gwynne Rohrs, CNM; Audra Trillana, CNP; Crystal Wilmhoff, CNP; Amanda Wirth, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 20-24

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.

. 1-4

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

. 0

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

. 0

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".

. 0

Workforce Counties

1. Enter the first zip code:

. 45219

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45238

4. Enter the second county:

. . . . . Hamilton

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

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; 2016 Ferguson Drive, Cincinnati, OH 45238

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)

. . . . . NO

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?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Public Health and General Preventive Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1043478670

DEA number

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

. . . . . FK0794861

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . YES

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . YES

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.

Contact Audit Trail for KALSY SAPNA

Date	User	Table	Field	New	Old
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	COUNTYID	Hamilton	Out of State
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	COUNTYID	Hamilton	Out of State
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States	
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States	
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States	
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	PHONE	5137217635	(336) 655-2544
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	PHONE	5137217635	
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	PHONE	5137217635	
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	ZIPCODE	45202	90403
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	ZIPCODE	45219	90403
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	STATECODE	OH	CA
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	STATECODE	OH	CA
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	CITY	Cincinnati	Santa Monica
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	CITY	Cincinnati	Santa Monica
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	ADDRESS2	Unit 102	
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	ADDRESS1	903 Adams Crossing	1223 Wilshire Avenue #668
9/13/2016 4:23:53 PM	Bates, J	CONTACTADDRESS	ADDRESS1	2314 Auburn Avenue	1223 Wilshire Avenue #668
9/12/2016 9:13:57 AM	Bates, J	CONTACTADDRESS	PHONE		(336) 655-2544
11/25/2014 11:58:40 AM	Adams, B	CONTACTADDRESS	COUNTYID	Hamilton	
11/25/2014 11:58:40 AM	Adams, B	CONTACTADDRESS	ADDRESS1	2314 Auburn Avenue	
11/25/2014 11:58:40	Adams, B	CONTACTADDRESS	CITY	Cincinnati	

AM					
11/25/2014 11:58:40 AM	Adams, B	CONTACTADDRESS	ZIPCODE	45219	
11/25/2014 11:57:59 AM	Adams, B	CONTACTADDRESS	ADDRESS1	1223 Wilshire Avenue #668	153 Cooper's Hawk Lane
11/25/2014 11:57:59 AM	Adams, B	CONTACTADDRESS	CITY	Santa Monica	Landenberg
11/25/2014 11:57:59 AM	Adams, B	CONTACTADDRESS	STATECODE	CA	PA
11/25/2014 11:57:59 AM	Adams, B	CONTACTADDRESS	ZIPCODE	90403	19350
11/25/2014 11:57:59 AM	Adams, B	CONTACTADDRESS	PHONE	(336) 655-2544	3366552544
11/25/2014 11:56:29 AM	Adams, B	CONTACTADDRESS	ADDRESS1	1223 Wilshire Avenue #668	153 Cooper's Hawk Lane
11/25/2014 11:56:29 AM	Adams, B	CONTACTADDRESS	CITY	Santa Monica	Landenberg
11/25/2014 11:56:29 AM	Adams, B	CONTACTADDRESS	STATECODE	CA	PA
11/25/2014 11:56:29 AM	Adams, B	CONTACTADDRESS	ZIPCODE	90403	19350
9/8/2014 11:39:25 AM	Mack, C	CONTACTSCHOOL	SCHOOLTYPEID	2	91
9/8/2014 11:39:25 AM	Mack, C	CONTACTSCHOOL	SCHOOLSTATUSID	4	0
9/8/2014 11:39:25 AM	Mack, C	CONTACTSCHOOL	DATESATTENDED	5/20/2005	8/1/2001 - 5/20/2005
9/8/2014 11:38:48 AM	Mack, C	CONTACTADDRESS	COMMENTS		
9/8/2014 11:38:48 AM	Mack, C	CONTACTADDRESS	COUNTYID	Out of State	
9/8/2014 11:38:37 AM	Mack, C	CONTACTADDRESS	PHONE	(336) 655-2544	3366552544
9/8/2014 11:38:37 AM	Mack, C	CONTACTADDRESS	COUNTYID	Out of State	
9/8/2014 11:38:24 AM	Mack, C	CONTACT	TITLE	Dr.	
9/4/2014 9:42:22 AM	Adams, B	CONTACT	GENDER	F	
9/4/2014 9:42:22 AM	Adams, B	CONTACT	DATEOFBIRTH	19770828	
9/4/2014 9:42:22 AM	Adams, B	CONTACT	BIRTHCITY	Torrance	
9/4/2014 9:42:22	Adams, B	CONTACT	BIRTHSTATE	CA	

AM					
9/4/2014 9:41:43 AM	Adams, B	CONTACTADDRESS	ADDRESS1	153 Cooper's Hawk Lane	
9/4/2014 9:41:43 AM	Adams, B	CONTACTADDRESS	CITY	Landenberg	
9/4/2014 9:41:43 AM	Adams, B	CONTACTADDRESS	STATECODE	PA	OH
9/4/2014 9:41:43 AM	Adams, B	CONTACTADDRESS	ZIPCODE	19350	
9/4/2014 9:41:43 AM	Adams, B	CONTACTADDRESS	PHONE	3366552544	
9/2/2014 2:52:32 PM	Dillard, P	CONTACT	OLRPASSWORD	*******	*******