Uniform Application for Licensure

Application ID: 221409
FID: 214844581
License Requested: MD
Submitted to: Kansas State Board of Healing Arts
Submission Date: 05/05/2017

Practitioner Name

Pentlicky, Sara Beth

Contact Information

Address

Public Access	Board Contact	Type	Address
No	Yes	Home	[redacted] UNITED STATES
Yes	No	Business	2001 E. Madison St Seattle, WA 98102 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	No	Business	(800) 769-0045	
No	Yes	Mobile	[redacted]	

Email

Public Access	Board Contact	Email
Yes	Yes	sara.pentlicky@gmail.com

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
	[redacted]	[redacted]1978	Plainfield, NJ UNITED STATES	F	1740456649	MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Jefferson Medical College of Thomas Jefferson University	1025 Walnut Street Philadelphia, PA 191075083 UNITED STATES	08/01/2002	05/31/2006	05/25/2006	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name: **University of Kentucky College of Medicine Program**
Lexington, KY UNITED STATES

Program Code: ACGME 2202011105

Attendance Dates:

Institution: University of Kentucky College of Medicine

Start Date: 07/01/2006

Training Specialty: Obstetrics & Gynecology

End Date: 06/30/2010

Program Type: Internship/Residency

Training Status: Completed

Hospital Name: **University of Pennsylvania**
Philadelphia, PA UNITED STATES

Program Code:

Attendance Dates:

Institution: University of Pennsylvania

Start Date: 07/01/2010

Training Specialty: Obstetrics and Gynecology/Gynecology

End Date: 06/30/2012

Program Type: Fellowship

Training Status: Completed

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		06/24/2004	Pass	1
USMLE Step 2 CK Examination		06/28/2005	Pass	1
USMLE Step 2 CS Examination		02/08/2006	Pass	1
USMLE Step 3 Examination		01/15/2007	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Idaho State Board of Medicine	ID	M-12403	03/31/2014	06/30/2018	Full	Active (Current, Valid)
Pennsylvania State Board of Medicine	PA	MD440124	05/24/2010	12/31/2018	Full	Active (Current, Valid)
Washington Medical Quality Assurance Commission	WA	MD60388725	07/19/2013	05/02/2018	Full	Active (Current, Valid)

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
None Reported						

Chronology of Activity Type

Practice/Emp/ Desc: **Planned Parenthood of the Great Northwest and the Hawaiian Island**

Chronology Type: Work

Address: 2001 E. Madison St
seattle, WA 98122
US

Attendance Dates:

Position/Dept: Staff Physician and Director of Special Services - OBGYN

Start Date: 03/01/2014

End Date: In Progress

Clinical %: 95

Admin %: 5

Employment: ● **Staff Privileges:** ● **Affiliation:** ○

Practice/Emp/ Desc: **University of Pennsylvania Department of OBGYN**

Chronology Type: Work

Address: 3400 Spruce St
Philadelphia, PA 19104
US

Attendance Dates:

Position/Dept: Assistance Professor - OBGYN

Start Date: 07/01/2012

End Date: 02/28/2014

Clinical %: 65

Admin %: 35

Employment: ● **Staff Privileges:** ● **Affiliation:** ○

Practice/Emp/ Desc: **University of Pennsylvania**

Chronology Type: Other Training

Address: Philadelphia, PA
US

Attendance Dates:

Position/Dept:

Start Date: 07/01/2010

End Date: 06/30/2012

Clinical %:

Admin %:

Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **University of Kentucky College of Medicine Program**

Chronology Type: Accredited Training

Address: Lexington, KY
US

Attendance Dates:

Position/Dept:

Start Date: 07/01/2006

End Date: 06/30/2010

Clinical %:

Admin %:

Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **Jefferson Medical College of Thomas Jefferson University**

Chronology Type: Medical Education

Address: Philadelphia, PA
US

Attendance Dates:

Position/Dept:

Start Date: 08/01/2002

End Date: 05/31/2006

Clinical %:

Admin %:

Employment: **Staff Privileges:** **Affiliation:**

Malpractice

None Reported

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

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

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

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

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

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

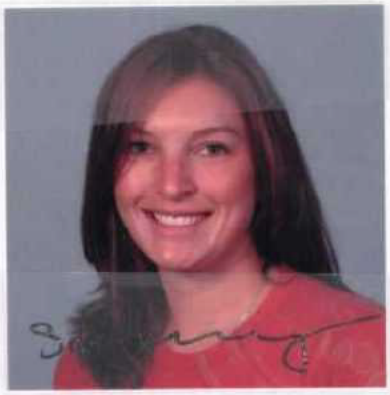
Applicant's Signature (must be signed in the presence of a notary)

PENTLICKY
Applicant's Printed Last Name

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

11/28/06 — [redacted]78
Date of Signature — Date of Birth

[redacted]
Applicant SSN



NOTARY

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

Dated 11/28/06

State of Kentucky County of Fayette

SUBSCRIBED AND SWORN TO before me this 28 day of Nov , 20 06

My commission expires: 01-15-08

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: Norene T. Ward, Norene T. Ward

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

69379

Omnibus has Literas Visuris

Salutem.

Quandoquidem **GRADUS ACADEMICI** cum in finem instituti fuerint, ut homines ingenio et doctrina praediti titulis praeter caeteros insignirentur, eo ut ipsis prosit, nec non aliorum provocetur industria et inter homines studium Virtutis et Bonarum Literarum augeatur; Quando etiam haec potissimum spectant amplissima illa jura nostro Collegio publico Diplomate collata. **Idcirco:**

NOTUM SIT, QUOD NOS, PRÆSES ET PROFESSORES

Universitatis Thomasinae Jeffersonianae

IN REPUBLICA PENNSYLVANIENSI,

Sara Beth Pentlicky Hominem probum, nobis devinctum, primum propter mores benevolos et omnes eas artes quæ optimum quemque ornant, qui etiam scientia eximia in Arte Medica, aeque ac Chirurgica nostro Collegio sibi acquisita nobisque examinatione publice habita plenius manifesta, se dignum **AMPLISSIMIS HONORIBUS ACADEMICIS** ostendit,

Doctorem in Arte Medendi

creavimus et constituimus: Eique praefato Sara Beth Pentlicky hujus DIPLOMATIS virtute singula Jura, Honores et Privilegia ad Gradum Doctoris in Arte Medendi, inter nos et ubique gentium pertinentia, libentissime et plenissime concessimus et rata fecimus.

In cujus rei fidem, **HÆC MEMBRANA**, Chirographis nostris subscripta et Sigillo Universitatis nostræ munita, testimonio sit.

Datum in URBE PHILADELPHIA, secundo die Junii Anno Humanæ Salutis MMVI Annoque Rerum Publicarum Americæ foederatarum Summæ Potestatis anno ducentesimo tricesimus

PRÆSES.

DECANUS, PRO PROFESSORIBUS.

SEAL VERIFIED

69379

720

This is a true copy of the diploma issued to **Sara Beth Pentlicky,** who graduated from **Jefferson Medical College** with a **Doctor of Medicine** degree on June 2, 2006.

Sheryl High

Sheryl High
Associate University Registrar

SEAL
VERIFIED

Thomas Jefferson University

University Office of the Registrar

TRANSLATION

DIPLOMA OF THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA

of

THOMAS JEFFERSON UNIVERSITY

Founded 1824

Jefferson Medical College

Jefferson College of Graduate Studies

Jefferson College of Health Professions

Jefferson University Physicians

TO ALL WHO SHALL SEE THESE WRITINGS, GREETING:

Forasmuch as academic degrees were instituted to the intent that persons endowed with learning and wisdom should be distinguished from others by honors, to the end that this might be profitable to them, and also that the industry of others might be stimulated and the exercise of virtue and the liberal arts be increased among mankind:-

And as the fullest rights conferred publicly by diploma in our College have this end in view:-

Therefore, be it known, that we, the President and Professors of Jefferson Medical College of Philadelphia of Thomas Jefferson University, in the Commonwealth of Pennsylvania, have created and constituted a Doctor in the Art of Healing, **SARA BETH PENTLICKY,** an honorable person endeared to us by correct morals and all those virtues which adorn every good person; who also, by his/her excellent knowledge of medical as well as of surgical art, acquired by him/her in our College, and manifested more fully in an examination publicly held by us, has shown himself/herself worthy of the fullest academic honors.

To the one thus referred to, **SARA BETH PENTLICKY,** have, by virtue of this diploma, most freely and fully granted and confirmed all the rights, honors and privileges belonging to the degree of **DOCTOR IN THE ART OF MEDICINE**, among ourselves, and all nations.

In evidence of which let this diploma, signed in our handwriting, and having appended the seal of the University, be a testimonial.

Given in the City of Philadelphia, on the **2nd day of June** in the year of human salvation **2006** and in the **230th year** of the sovereign power of the United States of America.

Sheryl High

Sheryl High
Associate University Registrar

SEAL OF UNIVERSITY

SEAL VERIFIED

69379

www.Jefferson.edu 1015 Walnut Street, Room G-22, Philadelphia, PA 19107-5099 • 215-503-8734 • Fax: 215-923-6974

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: 12/06/2016

Federation Credentials Verification Service

ATTN: FCVS

FCVSID: 69379

Examinee: Pentlicky, Sara Beth **Examinee ID:** 51336915

Alt Name(s): **Date of Birth:** [redacted]1978

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, 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
6/24/2004	Pass	[redacted]		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
6/28/2005	Pass	[redacted]		

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
2/8/2006	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
1/15/2007	Pass	[redacted]		

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

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

Examinee: Pentlicky, Sara Beth

Examinee ID: 51336915

Date of Birth: [redacted]1978

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.

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.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, 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 Physician Data Center 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.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

STATE OF IDAHO

BOARD OF MEDICINE

1755 Westgate Dr. Ste 140
Boise, Idaho 83704
(208) 327-7000
FAX (208) 327-7005
E-Mail info@bom.idaho.gov

December 27, 2016

CERTIFICATION

This is to certify that a search of the available records of the Idaho State of Medicine indicates the following:

SARA BETH PENTLICKY, MD

LICENSE NUMBER:	M-12403
LICENSE TYPE:	PHYSICIAN AND SURGEON
DATE ISSUED:	03/31/2014
LICENSE STATUS:	Current
LAST ACTION:	Renewed
MEDICAL SCHOOL:	JEFFERSON MED COLL-THOS JEFFERSON UNIV, PHILADELPHIA PA 19107
DISCIPLINARY ACTION:	No
EXPIRATION DATE:	06/30/2018

This license information was last updated on: 12/26/2016

If other information is needed, please contact the individual or the agency or institution which generated the information.

If disciplinary action is indicated details will be made available by photocopy from the public file upon written request.

Mary Leonard
Associate Director

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

P. O. Box 2649

Harrisburg, PA 17105-2649

05/31/2017

License Information

SARA BETH PENTLICKY

Seattle, Washington 98102

Profession:	Medicine	Status Effective Date:	05/24/2010
LicenseType:	Medical Physician and Surgeon	Issue Date:	05/24/2010
Specialty Type:		Expiration Date:	12/31/2018
License Number:	MD440124	Last Renewal:	12/10/2016
Status:	Active		

Disciplinary Action Details

No disciplinary actions were found for this license.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
P.O. Box 47866, Olympia, WA 98504-7866

December 27, 2016

KANSAS STATE BOARD OF HEALING ARTS
800 SW JACKSON
TOPEKA, KS 66612

Subject: Credential Verification

To Whom It May Concern:

This will verify the status of the Physician And Surgeon License for SARA PENTLICKY.

You may see blank sections because we do not have the information in our database or it is not applicable for this credential type. This information is valid from the date of this letter.

Year of Birth:	1978
Credential Number:	MD,MD60388725
Credential Type:	Physician And Surgeon License
Current Credential Status:	ACTIVE
First Credential Date:	07/19/2013
Current Expiration Date:	05/02/2018
Last Renewal Date:	02/22/2016
DISCIPLINARY ACTION:	No

This license information was last updated on: 12/20/2016

If you have questions, please call (360)-236-2768 for physicians and (360) 236-2771 for physician assistants, or visit our Online Provider Credential Search at www.doh.wa.gov.

Dawn Thompson

Dawn Thompson, Licensing Lead

UA **UNIFORM APPLICATION FOR STATE LICENSURE**

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this to the state board you are applying to for licensure, NOT to FSMB.

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public. Send this notarized affidavit to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB. Doing so will delay your state licensure.

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

I acknowledge that I have read and understand the Uniform Application for State 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 being granted to me by the Board.

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

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

Pentlicky
Applicant's printed last name

Sara
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

1/30/17
Date of signature (must correspond to date of notarization)

-fold up- -fold up-

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of WASHINGTON, County of KING,

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 30 day of January, 20 17.

Notary Public Signature:

My Notary Commission Expires: 8-9-2020

AMY SJOBERG NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 8-09-2020 (NOTARY PUBLIC SEAL)

Kansas State Board of Healing Arts

Addendum 1

Discipline applying for (check appropriate item):

☒ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

License Designation: Please select the license designation you are requesting.

☒ **Active** — A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

☐ **Federal Active** — A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ **Inactive** — A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

☐ **Exempt** — A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect. List intended professional activities: _____

Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☒ No
2. Give location of intended practice in Kansas _____
3. Primary Specialty _____

   American Board Certified _____ American Board Eligible _____

Statement of Health:

4. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your particular branch of the healing arts or your particular specialty? ☐ Yes ☒ No

   If yes, applicant shall file with this application, a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

Name (Printed or Typed): Sara Pentlicky **Date:** 5/31/17

ADDENDUM 2
KANSAS STATE BOARD OF HEALING ARTS

Please answer each of the following questions by putting a check (✓) in the appropriate box. All "yes" answers MUST be thoroughly explained in detail in a separate signed page. You are required to furnish complete details including date, place, reason and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.

If you are unsure of your response to a particular question, check (✓) the "yes" box and submit the appropriate form if required. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check (✓) the "no" box. It is your continuing duty to update the Board on any changes once the application has been submitted.

1. ☐ Yes ☑ No Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training or educational program, including but not limited to medical school, prior to completing the training?

2. ☐ Yes ☑ No Have you ever had any application for any professional license refused or denied by any licensing authority?

3. ☐ Yes ☑ No Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?

4. [redacted] Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

5. ☐ Yes ☑ No Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

6. ☐ Yes ☑ No Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?

7. ☐ Yes ☑ No Have you ever voluntarily surrendered any professional license?

8. ☐ Yes ☑ No Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation, or had any other disciplinary action taken against any professional license you have held?

9. ☐ Yes ☑ No Have you ever been notified or requested to appear before a licensing or disciplinary agency?

10. ☐ Yes ☑ No To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?

11 ☐ Yes ☑ No Has any professional association imposed any disciplinary action against you?

12. [redacted] Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?

13. [redacted] Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?

14 [redacted] Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?

15. [redacted] Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?

16 [redacted] Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?

17. ☐ Yes ☑ No Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?

18. ☐ Yes ☑ No Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?

19. ☐ Yes ☑ No Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?

20. ☐ Yes ☑ No Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

21 ☐ Yes ☑ No Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

22. ☐ Yes ☑ No Have you ever been court-martialed or discharged dishonorably from the armed services?

23. ☐ Yes ☑ No Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself?

24. ☐ Yes ☑ No Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?

25. ☐ Yes ☑ No Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company?

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JAN 10 2017

KSBHA

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): Sara Pertlicky **Date of Birth:** [redacted]/78

Please mail this document to the Kansas State Board of Healing Arts at the address above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. Pertlicky (type or print) for 5 years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. Pertlicky is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Alhambra Franey, MD

Street 1: 2026 Pemberton St

Street 2:

State/Zip: Philadelphia, PA 19146

Telephone: (785) 979-9617

Signature:

Date: 1/5/2016

A. Forey

Penn Medicine
Department of Obstetrics & Gynecology
3400 Spruce Street
1000 Courtyard
Phialdelphia, PA 19104

PHILADELPHIA PA 190
06 JAN 2017 PM 4 L

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Suite A
Topeka, KS 66612

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JAN 10 2017
KSBHA

Hospital *of the* University *of* Pennsylvania

66612-124473

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): Sara Pentlicky **Date of Birth:** [redacted]78

Please mail this document to the Kansas State Board of Healing Arts at the address above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. Sara Pentlicky (type or print) for 7 years; that he/(she) is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. Pentlicky is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Grace Shih, MD MAS

Street 1: 331 NE Thornton Place

Street 2:

State/Zip: Seattle, WA 98125

Telephone: (206) 520-2405

Signature: [signature]

Date: 1/7/17

SEATTLE WA 980

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JAN 17 2017

KSBHA

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level - Suite A.
Topeka, KS 66612

66612-12473

ADDENDUM 5

Kansas

WAIVER AGREEMENT AND STATEMENT
Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize the Kansas State Board of Healing Arts to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the Purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. Pursuant to K.S.A. 22-4701 *et seq.* and K.S.A. 22-5001, the Kansas State Board of Healing Arts may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the Kansas State Board of Healing Arts of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Kansas State Board of Healing Arts may choose to deny my application or grant me a limited or restricted license until the criminal history background check is completed.

I understand that, upon my request, the Kansas State Board of Healing Arts will provide me with a summary of the information contained in my Criminal History Background Report for the limited purpose of challenging the accuracy and/or completeness of the information contained in the report, but will not provide me with a complete copy of the Criminal History Background Report. I understand that I may obtain a prompt determination as to the validity of my challenge before the Kansas State Board of Healing Arts makes a final decision about my application for license to practice the healing arts. I further understand that I will not be provided access to information in my Criminal History Background Report under the following circumstances: 1) I am granted a full, unrestricted license, 2) I voluntarily withdraw an application for licensure, or 3) I am denied a license and have exhausted all my right to appeal the denial.

I have ☐ OR have not ☑ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

_____

_____

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 3805, and may result in the denial of my application pursuant to K.S.A. 65-2836 (a).

Signature	Date 12/27/16
Printed Name Sara Pentlicky	Date of Birth [redacted]78
Residential Address 2042 Eastlake Ave E Unit C	City Seattle State WA Zip 98102