

5424046



**ALASKA STATE MEDICAL BOARD**

Department of Community and Economic Development  
 Division of Occupational Licensing  
 (333 Willoughby Avenue - Ninth Floor)  
 Post Office Box 110806  
 Juneau Alaska 99811-0806  
 A - K: 907/465-2756 L - Z: 907/465-2541  
 E-Mail: [medicalboard@alaska.gov](mailto:medicalboard@alaska.gov)

**MED**

For Office Use Only  
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**JUNEAU**  
**MAY 23 2011**  
 Division of Corporations, Business  
 and Professional Licensing  
*CC SO [Signature]*

**APPLICATION FOR  
 RESIDENT PERMIT**

Resident Permit Fee \$50

**PART IV PERSONAL IDENTIFICATION INFORMATION**

(Type or Print Legibly)

1	Full Legal Name (Last, First, Middle)	Wallett, Sarah Mary		<input type="checkbox"/> Jr.
				<input type="checkbox"/> Sr.
2	Other Names Used (Incl. Maiden Name)			
3	Legal Name Changes (Provide copies)			
4	Social Security Number	[Redacted]	Date of Birth	[Redacted]
5	Place of Birth (City, State, Country)	Louisville, Kentucky USA		
6	Full Practice Address	Mailing Address (Include street address if using post office box) 1500 E medical center Dr SPC 5276 Women's Hospital FL4 Rm L4510		
		City Ann Arbor	State MI	Zip Code 48109
7	Full Residence Address	Mailing Address (Include street address if using post office box) [Redacted]		Duration at this address
		City [Redacted]	State [Redacted]	Yrs: Mos: 2
8	Telephones	Work	734 936 9434	Home
		[Redacted]		
9	E-Mail Address (Optional)	swallett@med.umich.edu		
10	Preferred Address of Record	<input checked="" type="checkbox"/> Use Practice Address		<input type="checkbox"/> Use Residence Address
11	Professional Designation	<input checked="" type="checkbox"/> Allopathic Physician (MD)		<input checked="" type="checkbox"/> Application by Credentials
		<input type="checkbox"/> Osteopathic Physician (DO)		<input type="checkbox"/> Application by Examination (Alaska is first state of licensure)
12	Previous License or Permit in ALASKA?	<input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		If YES, what type and when: Type: _____ Year: _____

**RESIDENT ROTATION ASSIGNMENT** (Identify the Alaska facility where you will be serving your rotation.)

13. Name of Institution	Location	Dates of Rotation
ALASKA NATIVE MEDICAL Ctr	Anchorage	From: 8/1/11 To: 8/31/11

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**PART II EDUCATION**

**14. Medical School Education**

Name of Institution	Location	Date Graduated
Jefferson Medical College	Philadelphia PA	2009

**15. Postgraduate Training** (List Internship, Residency, or Fellowship Training Programs Chronologically)

Name of Institution	Address	Dates From/To	Compl? Yes/No
1 University of Michigan	1500 E Medical Center Dr Ann Arbor MI 48109	6/2009 -	No
2			
3			
4			

**16. ECFMG Certification - International Graduates Only**

Have you taken the ECFMG exam?  Yes Certificate No. \_\_\_\_\_  No  
 Attach a certified true copy of the certificate to this application.

**17. Specialty**

Specialty/Subspecialty	Board Certified? Yes/No/Date	What Board?	Recertification Date

**PART III PROFESSIONAL ACTIVITIES**

**18. Professional Licensure**

Please list all states, territories, provinces, or foreign countries in which you are or have ever been licensed as any health care professional. Include instructional or training permits.

	Location (State, territory, etc.)	Date Issued		Location (State, territory, etc.)	Date Issued
1	Michigan	2009	6		
2	Ghana	2011	7		
3			8		
4			9		
5			10		

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

**19. Medical Malpractice History**

Have you ever had any claims of malpractice filed against you?  No  Yes

If Yes, please list all claims of malpractice filed against you below. Include all settlements, judgments, awards, and claims, even if no money was paid. For each case listed below, provide an explanation and documentation. Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include a brief description regarding the nature of the case, the allegations, and your response to the allegations. *Letters from attorneys or insurance carriers may not be substituted for this required explanation.* Documentation includes a copy of the order for settlement, dismissal, or removal from the case, or other documentation to support your explanation. Please do not send all of the motions or filings for the case.

Case Number	Date of Case (Mo/Yr)	Junsdiction (State, etc.)	Nature of Allegation	Amount of Settlement Paid on Your Behalf
1				
2				
3				
4				
5				

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

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**SPECIAL INSTRUCTIONS FOR PARTS IV AND V**

In responding to the questions in Parts IV and V below, please check the appropriate box next to each question. A "Yes" response to a question does not automatically result in a denial of license application. **For each "Yes" response to any question, you must provide an explanation and documentation.** Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. When in doubt about your response, disclose and provide the explanation requested. Please answer parts A and B of each question. Documentation includes copies of court orders, charging documents, board or license actions, etc.

**CONFIDENTIALITY**

*The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.*

**PART IV DISCIPLINARY HISTORY**

**IMPORTANT! PLEASE READ BEFORE ANSWERING THE DISCIPLINARY HISTORY QUESTIONS**

For the purposes of this application, the word "discipline" is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Academic Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. Please include non-reported disciplinary actions. Failure to disclose past history may be grounds for disciplinary sanctions.

**WHEN IN DOUBT, DISCLOSE AND EXPLAIN.**

- 20a.  No  Yes Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?
- 20b.  No  Yes Is any such action pending?
  
- 21a.  No  Yes Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal?
- 21b.  No  Yes Is any such action pending?
  
- 22a.  No  Yes Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction?
- 22b.  No  Yes Is any such action pending?

Continued on next page

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#### Part IV Disciplinary History continued

- 23a.  No  Yes Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction?
- 23b.  No  Yes Is any such action pending?
- 24a.  No  Yes Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges (except for late medical records)?
- 24b.  No  Yes Is any such action pending?
- 25a.  No  Yes Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction, or termination?
- 25b.  No  Yes Is any such action pending?
- 26a.  No  Yes Have you ever been disciplined by a medical school or post-graduate training program, including academic probation? (Please read definition of "discipline" on page 3).
- 26b.  No  Yes Is any such action pending?
- 27a.  No  Yes Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)? (Please read definition of "discipline" on page 3.)
- 27b.  No  Yes Is any such action pending?
- 28a.  No  Yes Have you ever been under investigation or inquiry by any medical licensing jurisdiction or authority?
- 28b.  No  Yes Is any such action pending?
- 29a.  No  Yes Have you ever had a medical license application denied by any medical licensing jurisdiction or authority?
- 29b.  No  Yes Is any such action pending?
- 30a.  No  Yes Have you ever voluntarily or involuntarily withdrawn an application for a license to practice medicine in any United States jurisdiction or any international jurisdiction?
- 30b.  No  Yes Is any such action pending?
- 31a.  No  Yes Have you ever voluntarily or involuntarily surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction?
- 31b.  No  Yes Is any such action pending?
- 32a.  No  Yes Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine?
- 32b.  No  Yes Is any such action pending?

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**PLEASE READ THESE QUESTIONS CAREFULLY BEFORE YOU RESPOND.**

If you respond 'yes' to any question, please attach a complete explanation to your application. Failure to disclose past history may be grounds for disciplinary sanctions.

**WHEN IN DOUBT, DISCLOSE AND EXPLAIN.**

**PART V PERSONAL HISTORY**

Please refer to Special Instructions on page 4. For the purposes of the questions in this section, the following phrases or words are defined:

**"Ability to Practice Medicine"** includes, but is not limited to, the cognitive capacity to make appropriate clinical diagnoses and exercise reasonable medical judgments and to learn and keep abreast of medical developments; 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 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.

**"Chemical Substance(s)"** any natural or synthetic chemical substance, alcohol, drugs, or medications, including those chemical substances taken pursuant to a valid prescription for legitimate medical purpose and in accordance with the direction(s) of the prescribing physician, as well as those used illegally.

**"Controlled Substances"** means any substance as defined in either Alaska Statute 11.71.900 or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513) and any subsequent amendment(s).

**"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application; rather, "currently" means recently enough so that the event, condition, behavior, impairment, limitation, etc., may have an ongoing impact on the applicant's ability to practice medicine in a competent manner.

**"Illegal Drug Use"** means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed physician who prescribed the controlled substance or dangerous drug.

- 33.  No  Yes Has your ability to practice medicine in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?
- 34.  No  Yes Are you currently experiencing any medical condition or disorder that impairs your judgment or that otherwise affects your ability to practice medicine in a safe and competent manner?
- 35.  No  Yes Since completing your postgraduate training, have you ever been physically or mentally unable to practice medicine for a period of sixty (60) days or more?
- 36.  No  Yes Are you currently the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner?
- 37.  No  Yes Have you ever been diagnosed with, been treated for, or do you currently have pedophilia, exhibitionism, or voyeurism, or any other sexual behavior disorder? (Please note that "sexual behavior disorder" does not include sexual preference.)
- 38.  No  Yes Are you currently engaged in the illegal use of any drug, whether by ingestion, inhalation, injection, or any other method?
- 39.  No  Yes Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?

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**Part V Personal History continued**

40.  No  Yes Have you ever been voluntarily or involuntarily committed or confined to any facility for mental health care?

41.  No  Yes Have you ever been diagnosed with, treated for, or do you currently have (check the appropriate condition):

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Depressive Neurosis         | <input type="checkbox"/> Kleptomania |
| <input type="checkbox"/> Hypomania        | <input type="checkbox"/> Any Dissociative Disorder   | <input type="checkbox"/> Pyromania   |
| <input type="checkbox"/> Schizophrenia    | <input type="checkbox"/> Any Psychotic Disorder      | <input type="checkbox"/> Delirium    |
| <input type="checkbox"/> Major Depression | <input type="checkbox"/> Any Organic Mental Disorder | <input type="checkbox"/> Paranoia    |

42.  No  Yes Have you ever taken, or are you currently taking, any chemical substance for any of the disorders listed in question 41 above?

43.  No  Yes Have you ever been adjudicated or declared incompetent or been the subject of an incompetency proceeding?

If you have checked "Yes," to any question above, please attach a detailed explanation.

**PART VI SWORN STATEMENT**

I hereby certify that the information contained in this application is true and correct to the best of my knowledge. I further certify that all credentials supplied by me are true and correct and that the photograph that appears below is a true likeness of myself taken within the past 60 days. I understand that any false information or falsification or credentials may result in the denial of a license or permit to practice medicine in the state of Alaska.

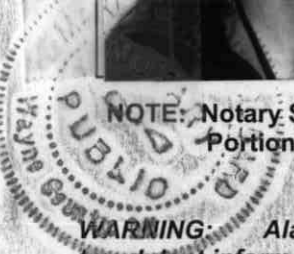
Applicant Signature *Aurora M. Wallitt* Date 5/9/11

**You must sign and date this application in front of the notary public.  
Applicant signature date and notary public date must be the same.**



SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for the State of Michigan this 9<sup>th</sup> day of May, 20 11.

Notary Signature *Marlene Ann Woodard*  
My commission expires: 4/12/2012



**NOTE: Notary Seal Must Overlie A Portion of the Photograph.**

**WARNING: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application is subject to imprisonment for not more than one year, a fine of not more than \$5,000, or both.**

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## AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, Sarah Mary Walleth, residing at

[Redacted Address]

(Please print full address)

\_\_\_\_\_ hereby authorize the

Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business and Professional Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the Division to discuss my records with persons or organizations that are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Sarah M Walleth  
Signature of Applicant

04/29/2011  
Date

[Redacted]  
Home Phone Number

(734) 936-9434  
Work Phone Number

[Redacted]  
Date of Birth

[Redacted]  
Social Security Number

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State of Alaska  
 Department of Commerce, Community, and Economic Development  
 Division of Corporations, Business and Professional Licensing  
 PO Box 110806, Juneau, Alaska 99811-0806  
 Phone: (907) 465-2550  
 Fax: (907) 465-2974

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**CREDIT CARD PAYMENT**

For security purposes, please **do not email** credit card information. Fax or mail this form to the Division. Completion of this form is not proof of payment until the division processes the information contained herein. If any information on this form is illegible, the form will be rejected. Please print.

Name of Applicant or Licensee: Sarah Mary Wallett  
*Corporate or Individual (first, middle, last)*

License Number (if applicable): \_\_\_\_\_

Type of License: Resident Permit

I wish to make payment by credit card for the following:  
*(check all that apply)*

- |   | Amount |
|---|--------|
| <input checked="" type="checkbox"/> Application fee | 50.00  |
| <input type="checkbox"/> License (or renewal) fee   | _____  |
| <input type="checkbox"/> Fine                       | _____  |
| <input type="checkbox"/> Other (specify): _____     | _____  |

**Total: 50.00**

Print Name on Credit Card: Marlene Woodard

Complete Mailing Address: 1500 E. Medical Center Drive  
Ann Arbor, MI 48109-5276

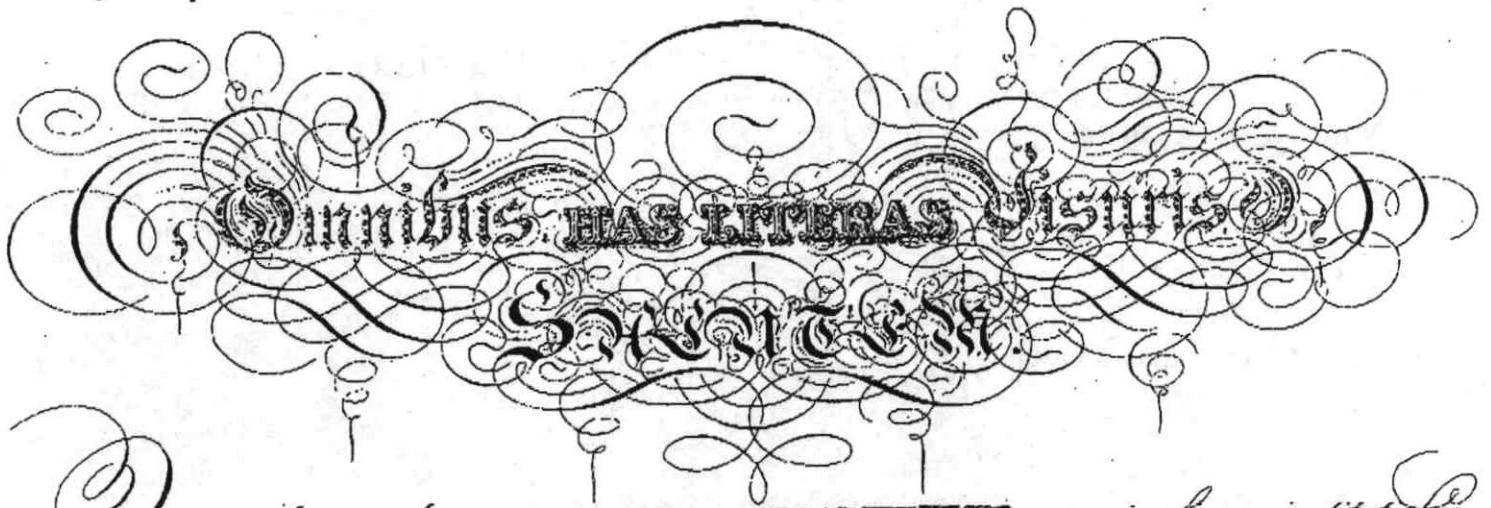
Telephone Number: 734.936.9434

Email Address (optional): wmarlene@med.umich.edu

Signature of Credit Card Holder: *Marlene Woodard*

017

Credit Card Type (check one):  VISA  MASTERCARD



Quandoquidem **GRADUS ACADEMICI** sum in fœnem instituti sũe  
runt, ut homines ingenio et doctrina præditi, titulis præter ceteros insignirentur: eo ut ipsi  
possit, nec non alicrum provocetur industria et, inter homines, studium Virtutis, et Romanum  
Litterarum, augeatur. Quando, etiam, hæc potissimum spectant, amplissima illa jura  
nostro Collegio, publico Diplomas, collatu. **Idcirco**

**NOTUM SIT, QUOD NOS, PRÆSES ET PROFESSORES**  
**Collegii Medicinalis Jeffersoniani Philadelphiensis**  
**Universitatis Thomasinae Jeffersonianae**  
**IN REPUBLICA PENNSYLVANIENSIS.**

**Sarah Mary Wallett**

**Nominem** probum, nobis devotissimum  
propter mores benevolos et omnes eas artes qua, optimum, quemque, ornant, qui, etiam, sum  
tia, excimia, in Arte Medica, æque, ac Chirurgica, nostro Collegio, sibi, acquisita, nobisque  
examinatione, publice, habita, plenius manifesta, se, diuino, **AMPLISSIMIS HONORIBUS**  
**ACADEMICIS**, ostendit. **Doctorem in Arte Medendi** creavimus, et, constituimus:

Et, que, præfate, Sarah Mary Wallett, hujus **DIPLOMATIS** virtute, singula, Juris,  
Honores et Privilegia, ad **Gradum Doctoris in Arte Medendi**, inter nos, et, ubique, genti  
um, pertinentia, libentissime, et, plenissime, concessimus, et, rata, fecimus.

In, cuius, rei, fidem, **HEC MEMBRANA**, Chirographis, nostris, subscripta, et, Si  
gillo, Universitatis, nostrae, munita, testimonio, sit.

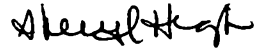
Datum, in **URBE PHILADELPHIA**,  
vicesimo, nono, die, Maii, Anno, Hu-  
mana, Salutis, **MMIX**, Annoque  
Horum, Publicarum, Americae, Federatae,  
num, Summae, Potestatis, anno, ducentesimo, vigesimo, tertio.



*[Signature]*  
**PRÆSES.**  
*[Signature]*  
**DECANUS, PRO PROFESSORIBUS.**



**THIS IS A TRUE COPY OF THE DIPLOMA ISSUED TO SARAH MARY WALLETT  
WHO GRADUATED FROM JEFFERSON MEDICAL COLLEGE WITH A DOCTOR OF  
MEDICINE DEGREE ON MAY 29, 2009.**



**SHERYL HIGH  
ASSOCIATE REGISTRAR**

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## VERIFICATION OF MEDICAL/OSTEOPATHIC SCHOOL EDUCATION RESIDENT APPLICATION

**Instructions to the Applicant:**

Type or print legibly. Complete the identification portion of this form below and send to the medical school from which you received your diploma.

NAME (Last, First, Middle)		Date of Birth (MM-DD-YYYY)	Social Security Number
Walleth, Sarah Mary			
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE		DATE SIGNED	
Sarah M Walleth		04/29/2011	

Applicant: Do not detach - do not write below this line.

**MEDICAL SCHOOL**

Please complete the information below and return this document directly to the Alaska board at the letterhead address.

Full Medical School Name JEFFERSON MEDICAL COLLEGE

Location PHILADELPHIA, PA

Exact Date on School Diploma MAY 29, 2009

During this physician's medical school education, was he/she ever investigated by the school or disciplined by the school for any reason? Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted, or otherwise disciplined.

No  Yes

If you responded "Yes" to this question, please provide a detailed explanation of the action and the reason for the action.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed Sheryl High

(SEAL, If Applicable)

Printed Name SHERYL HIGH

Title ASSOCIATE REGISTRAR

Date 6/15/11



June 15, 2011

Founded 1824

Jefferson Medical  
College

**Alaska State Medical Board**

Jefferson College of  
Graduate Studies

**RE: SARAH MARY WALLETT, M.D.**

Jefferson College of  
Health Professions

Jefferson University  
Physicians

**Attached is a translated copy of the medical school diploma for Sarah Mary Wallett, who entered into Jefferson Medical College on August 8, 2005 as a First year student, was in attendance at this institution for the next several years and was given the degree of Doctor of Medicine on May 29, 2009.**

**The enclosed translation has the original medical school seal that is required for verification purposes.**

Sincerely,

**Sheryl T. High  
Associate University Registrar  
Medical College**

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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, SARAH MARY WALLETT, 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, SARAH MARY WALLETT 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 29TH day of May in the year of human salvation 2009 and in the 233rd year of the sovereign power of the United States of America.

Sheryl T. High  
Associate University Registrar

SEAL OF UNIVERSITY

ORIGINAL

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**Jefferson™**

University Office of the Registrar  
1015 Walnut Street, Curtis Bldg., Suite G-22  
Philadelphia, PA 19107-5099

06 MAILED AT  
READING PA  
DROP SHIPMENT  
AUTHORIZATION 139

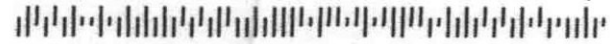
PRESORTED  
FIRST CLASS



UNITED STATES POSTAGE  
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**P. O. Box 110806**  
**Juneau, Alaska 99811-0806**

126 DEKZSS1 99811



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### VERIFICATION OF GOOD STANDING FROM RESIDENCY TRAINING PROGRAM

**Instructions to the Resident Applicant:** Complete Parts I, II, and III below. Type or print legibly. Submit the form to your residency program director for completion.

#### PART I RESIDENT APPLICANT

Name (Last, First, Middle)	Maiden or Other Names Used	Date of Birth	MD/DO
Walleth, Sarah Mary			MD

#### PART II RESIDENCY PROGRAM

Name of Program	University of Michigan Health System, Dept of Ob/Gyn
Mailing Address	4510 Women's Hospital, SPC 5276 1500 E medical center Dr Ann Arbor MI 48109
Telephone	734-936-9434

#### PART III ROTATION AUTHORIZED FOR

Name of Alaska Facility, Hospital, Clinic	Location	Dates of Rotation	
		From	To
Southcentral Foundation ALASKA NATIVE MEDICAL CTR	ANCHORAGE, AK	8/1/11	8/31/11

Applicant: Do Not Write Below This Line - Do Not Detach

**Instructions to Program Director:** Please complete Part IV below. Mail this form to the board at the letterhead address.

#### PART IV CERTIFICATION OF GOOD STANDING

I HEREBY CERTIFY that the resident physician named above is a resident in good standing at the residency program shown above. There have been no disciplinary sanctions against this resident during his/her training in this program. This physician will be serving a portion of his/her clinical training at the Alaska institution named above. This program is approved by the Accreditation Council on Graduate Medical Education of the American Medical Association or the Royal College of Physicians and Surgeons of Canada.

*Diana Curran*  
 Signature, Physician Program Director  
 Date Signed 5/9/11

Diana Curran, MD  
 Printed Name  
 Telephone 734 9369434



**RECEIVED  
JUNEAU**

**MAY 23 2011**

Division of Corporations, Business  
and Professional Licensing



# ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development  
 Division of Corporations, Business and Professional Licensing  
 (333 Willoughby Avenue - Ninth Floor)  
 Post Office Box 110806  
 Juneau Alaska 99811-0806  
 A - K: 907/465-2756 L - Z: 907/465-2541  
 E-Mail: medicalboard@alaska.gov

## MED

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**JUN 09 2011**

Division of Corporations, Business  
and Professional Licensing

## ACCEPTANCE OF RESPONSIBILITY BY ALASKA FACILITY, HOSPITAL, OR CLINIC

### Instructions to the Resident Applicant:

Complete the information in Parts I and II below. Type or print legibly. Mail the form to the Alaska facility, hospital, or clinic where you intend to serve your residency rotation.

### PART I RESIDENT APPLICANT

Name (Last, First, Middle)	Maiden or Other Names Used	Date of Birth	MD/DO
Walleth, Sarah Mary			MD

### PART II RESIDENCY PROGRAM

Name of Program	University of Michigan Health System, Dept of Ob/Gyn
Mailing Address	14510 Women's Hospital, SPC 5276 1500 E medical center Dr Ann Arbor MI 48109
Telephone	734-936-9434

Applicant: Do Not Write Below This Line - Do Not Detach

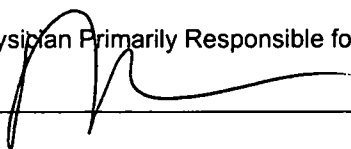
### Instructions to the Alaska Facility:

Please complete Part III below, sign Part IV, and return this document directly to the board at the letterhead address.

### PART III ROTATION AUTHORIZED FOR:

Name of Alaska Facility, Hospital, or Clinic	Alaska Native Medical Center	Dates of Rotation--From/To	8-1-2011 to 8-29-11
Address	4315 Diplomacy Dr. Anchorage, AK 99508		

Alaska Physician Primarily Responsible for Training/Supervision:

Signature  Printed Name M. A. N. A. S. A. Date 6/4/11

### PART IV VERIFICATION OF ACCEPTANCE OF RESPONSIBILITY

I CERTIFY THAT the Resident Physician named above has been accepted by this institution to serve as a resident. This physician will be serving a portion of his/her clinical training at the Alaska institution named above. This institution accepts responsibility for this physician's training and supervision while he/she is located at this institution.

Signature, Physician Clinical Director		Date	<u>5-25-2011</u>	Printed Title	<u>Med Dir Dept Ob/Gyn</u>
Printed Name	<u>Donna S Galbreath</u>		<u>NAETHG/6</u>	Telephone	<u>907 429 4205 907-729-</u>

Southcentral Foundation

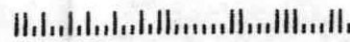
4501 Diplomacy Drive, Suite 200  
Anchorage, AK 99508



Alaska State Medical Board  
Dept. of Commerce, Community & Econ.  
Division of Corporations, Business & Prof.  
333 W. Loughby Ave. - 9th floor  
Juneau, Ak 99811-0806

(3 enclosures)

9980131770





RECEIVED

MAY 11 2011

ANCHORAGE  
ALASKA STATE MEDICAL BOARD

JENNIFER M. GRANHOLM  
Governor

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JANET OLSZEWSKI  
Director

**VERIFICATION OF LICENSURE  
MICHIGAN BOARD OF MEDICINE  
VERIFICATION OF LICENSURE AS OF 05/11/2011**

**NAME:** Sarah Mary Wallett

**BIRTHDATE:** [REDACTED]

**ADDRESS:** L4510 Womens  
1500 E Medical Center Drive  
Ann Arbor MI 481095276

**TYPE:** Medical Doctor - Educational Limited

**ORIGINAL DATE:** 06/16/2009

**LICENSE NUMBER:** 4301094048      **STATUS:** Active

**EXPIRATION DATE:** 06/30/2012

**OBTAINED BY:** Application

**EXAM DATE**                      **EXAM TYPE**                                      **EXAM SCORE OR RESULT**

**DISCIPLINARY ACTION**                      NONE

**OPEN FORMAL COMPLAINTS**                      NONE

This license information was last updated on 05/11/2011

**RECEIVED  
JUNEAU**

**MAY 17 2011**

Division of Corporations, Business  
and Professional Licensing

**Patredis, Miriam (CED)**

---

**From:** support@veridoc.org  
**Sent:** Wednesday, May 11, 2011 7:56 AM  
**To:** Patredis, Miriam (CED)  
**Subject:** License Verification Statement - Wallett, Sarah  
**Attachments:** v82018AA.pdf



**Verification of Licensure Status**

The attached verification report has been sent to you by the VeriDoc.org website. This email can be verified as coming from this site by clicking on the link below.

[Validate Verifications](#)

Physician: Wallett, Sarah

Transaction ID: 82018

Confirmation Number: 14511919324921794318

**RECEIVED  
JUNEAU**

**MAY 17 2011**

Division of Corporations Business  
and Professional Licensing



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

STEVEN H. HILFINGER  
DIRECTOR

**VERIFICATION OF LICENSURE  
MICHIGAN BOARD OF PHARMACY  
VERIFICATION OF LICENSURE AS OF 06/21/2011 RECEIVED**

ALASKA STATE MEDICAL BOARD  
PO BOX 110806  
JUNEAU AK 99811-0806

JUN 29 2011

DIVISION OF  
OCCUPATIONAL LICENSING  
JUNEAU

**NAME:** Sarah Mary Wallett  
**ADDRESS:** L4510 Womens  
1500 E Medical Center Drive  
Spc 5276  
Ann Arbor, MI 48109-5276

**BIRTHDATE:** [REDACTED]

**TYPE:** CS - 1 **ORIGINAL DATE:** 06/16/2009  
**LICENSE NUMBER:** 5315040271 **STATUS:** Active **EXPIRATION DATE:** 06/30/2012  
**OBTAINED BY:** Application

**DISCIPLINARY ACTION** NONE

**OPEN FORMAL COMPLAINTS** NONE

**ORIGINAL**

  
STACIE C. NOEL



\*\*\*6/24/11 LANSING MICH 489\*\*\*

State of Michigan  
Department of Community Health  
**Bureau of Health Professions**  
P.O. Box 30670  
Lansing, Michigan 48909-8170

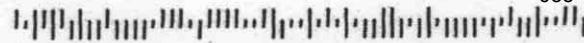
PRESORTED  
FIRST CLASS



UNITED STATES POSTAGE  
 PITNEY BOWES  
02 1M \$ 00.34  
0008001360 JUN 23 2011  
MAILED FROM ZIP CODE 4891



D-SX951 99811



035

July 12, 2011

Department of Commerce, Community, and  
Economic Development  
Division of Corporations, Business, and  
Professional Licensing  
Att: Michele Johnston  
333 Willoughby Avenue – Ninth Floor  
P.O. Box 110806  
Juneau, AK 99811-0806

**RE: Ghana License**

To Whom It May Concern:

I am scheduled to rotate at the Alaska Native Medical Center/South Central Foundation in August 2011. We have made numerous attempts to have the Medical and Dental Council in Ghana verify my Ghana license. We mailed the state licensing form to the council on June 6<sup>th</sup> and June 14<sup>th</sup> requesting that the form be completed and mailed directly to the Alaska State Medical Board. I am requesting that the Alaska State Medical Board grant me a resident license for the month of August because of our due diligence to acquire the verification. I await your response.

Thank you for your attention to this matter.

Sincerely,

A handwritten signature in black ink, appearing to read "Sarah Wallett". The signature is fluid and cursive, with the first name "Sarah" and last name "Wallett" clearly distinguishable.

Sarah Wallett, M.D., PGY III  
University of Michigan  
Department of Obstetrics and Gynecology

**RECEIVED  
JUNEAU**

**JUL 18 2011**

Division of Corporations, Business  
and Professional Licensing



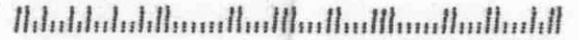
**Dept of Obstetrics & Gynecology**

Women's Hospital L4100  
1500 E. Medical Center Dr  
Ann Arbor, MI 48109-5276



Dept. of Commerce, Comm. & Economic Dev.  
Div. of Corp, Bus, and Professional Licensing  
Att: Michele Johnston  
333 Willoughby Ave. - Ninth Floor  
Juneau, AK 99811-0806

95801+1770





**Marlene Woodard**  
**Residency Program Coordinator**  
**Department of Obstetrics & Gynecology**  
**1500 E. Medical Center Drive**  
**Women's L4510, Box 5276**  
**Ann Arbor, Michigan 48109-5276**  
**PHONE: (734) 936-9434**

July 12, 2011

Department of Commerce, Community, and  
Economic Development  
Division of Corporations, Business, and  
Professional Licensing  
Att: Michele Johnston  
333 Willoughby Avenue – Ninth Floor  
P.O. Box 110806  
Juneau, AK 99811-0806

**RE: Sarah Walleth, M.D.**

To Whom It May Concern:

This letter is intended to document that we have made numerous attempts to request Ghana licensure verification for Sarah Walleth, M.D. The Alaska license verification form has been mailed to the Medical & Dental Council in Ghana and at this time we have not received receipt of the requested verification. Enclosed is a copy of the receipt that was received from Ghana for her temporary 30-day registration.

Please do not hesitate to contact me at 734.936.9434 should you have any further questions regarding the Ghana license.

Sincerely,

A handwritten signature in cursive script that reads 'Marlene Woodard'.

Marlene Woodard  
Residency Coordinator  
Department of Obstetrics and Gynecology  
University of Michigan Health System

**RECEIVED  
JUNEAU**

**JUL 18 2011**

Division of Corporations, Business  
and Professional Licensing

MINISTRY OF HEALTH / GHANA HEALTH SERVICE

RECEIPT  
TO BE HANDED TO  
PAYER



MOH  
GHS No. 09A/0882003

Station *Accra*

*2-1-2011*

GHC 580 Gp

\*Cheque No  
Money/Postal Order No.

Received from *Dr. Walleth Sarah Mary*

the sum of *five hundred and eighty*

*Ghana Cedis*  
and *Ghana Pesewas on account of*

*Temporary Registration*

\* Delete where inapplicable

Signed *[Signature]*

**PHARMACY & DENTAL CORP**

**RECEIVED  
JUNEAU**

**JUL 18 2011**

Division of Corporations, Business  
and Professional Licensing



Marlene Wood  
1500 E. Medic  
L4510 Womer  
Ann Arbor, MI 48109-5276



UNITED STATES POSTAL SERVICE  
184  
0992 # 01.000 PB8707523  
3390 MAILED FROM ANN ARBOR MI 48109  
JUL 12 11

ATT: *Michelle Johnston*  
Department of Commerce, Community, and  
Economic Development  
Division of Corporations, Business and  
Professional Licensing  
333 Willoughby Avenue - Ninth Floor  
P.O. Box 110806  
Juneau, AK 99811-0806



# ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing  
(333 Willoughby Avenue - Ninth Floor)  
Post Office Box 110806  
Juneau Alaska 99811-0806  
A - K: 907/465-2756 L - Z : 907/465-2541  
E-Mail: medicalboard@alaska.gov

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**MAY 24 2011**

Division of Corporations, Business  
and Professional Licensing

## PHYSICIAN BOARD ACTION DATA BANK INQUIRY

**Instructions to the Applicant:**

Please complete the information below. Type or print legibly. MAIL THIS REQUEST FORM TO.

Federation of State Medical Boards  
400 Fuller Wiser Rd., Suite 300  
Euless TX 76039-3855

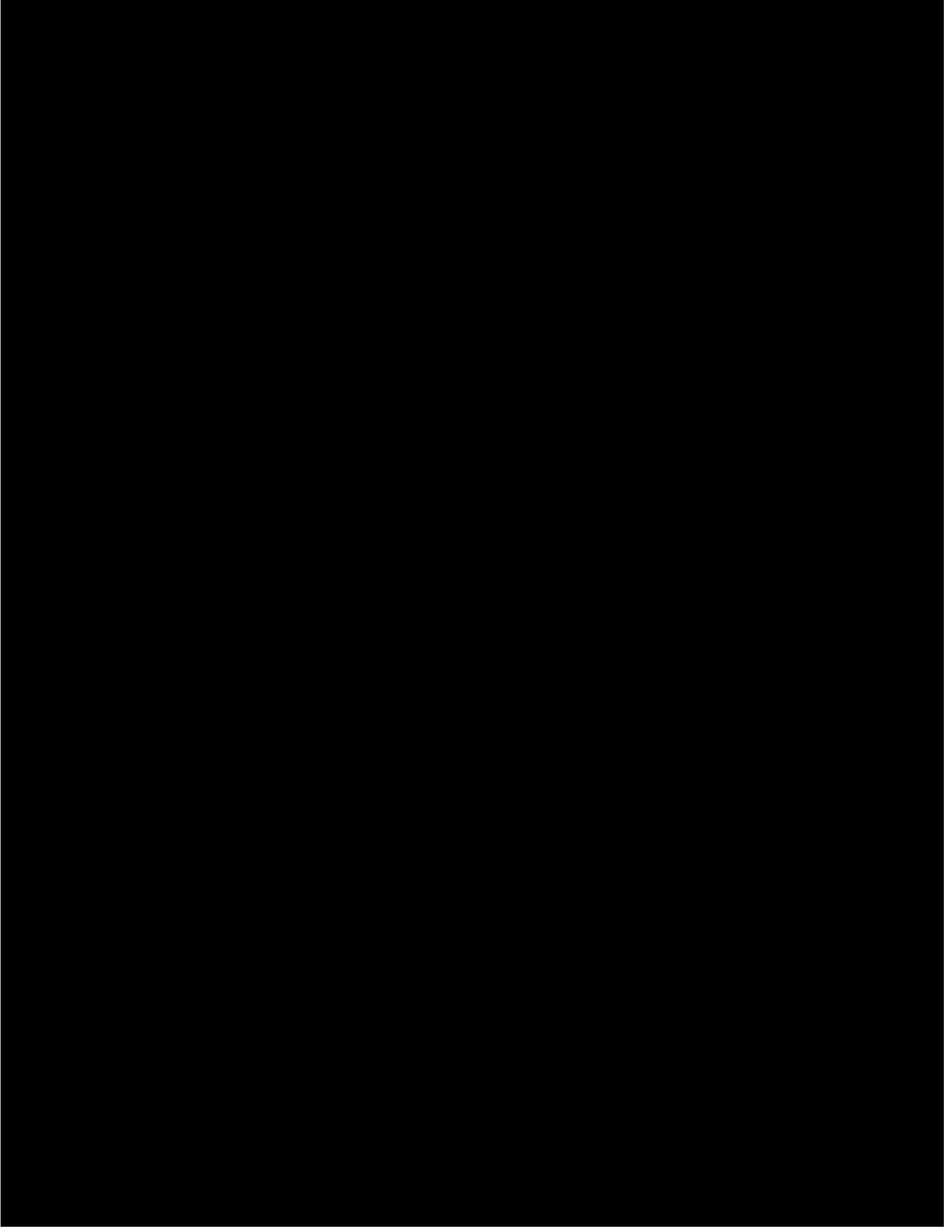
Full Name (Last, First, Middle)		Maiden or Other Names Used.	Date of Birth (MM/DD/YYYY)
Walleth, Sarah Mary			
Mailing Address (Street)		Place of Birth	
L4510 Women's Hospital SPC 5276 1500 E medical center Dr		Louisville, KY USA	
City/State/Zip		Social Security Number	
Ann Arbor MI 48109			
Medical/Osteopathic School (Name and Location)	Year of Graduation	If International Grad, ECFMG No	
Jefferson medical college Philadelphia PA	2009		

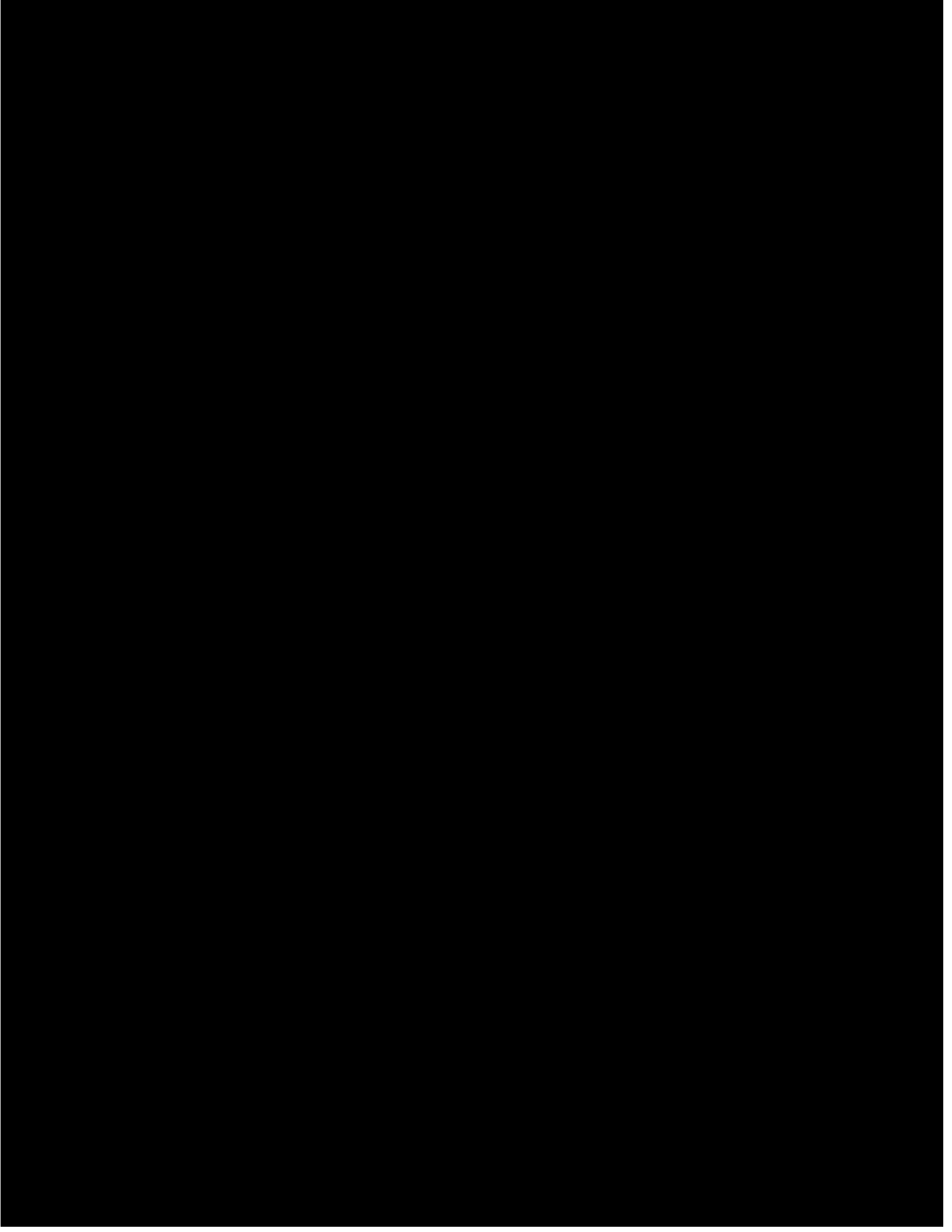
Applicant: Do Not Write Below This Line - Do Not Detach

**Instructions to the Data Bank Staff:**

Please search the data bank for any record of this practitioner. Please forward your report to the medical board at the letterhead address.

<p><b>FOR FEDERATION USE ONLY</b></p> <p><b>WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN</b></p> <p><b>MAY 17 2011</b></p> <p><i>Humayun J. Chaudhry</i> Humayun J. Chaudhry, D.O., FACP President and CEO</p>
--





**STATE  
MEDICAL  
BOARDS**

400 FULLER WISER ROAD, SUITE 300  
EULESS, TEXAS 76039-3856



Alaska State Medical Board  
Attn: Debra J. Stover  
333 Willoughby Ave. 9<sup>th</sup> Fl  
Juneau, AK 99811-0806

9980191770



**Johnston, Michelle (CED)**

---

**From:** Johnston, Michelle (CED)  
**Sent:** Tuesday, July 12, 2011 9:35 AM  
**To:** 'Woodard, Marlene'  
**Subject:** RE: Sarah Wallett

Marlene,

*except*

Looks good accept the letter need to be written/signed by the applicant. Also, please note that the state of Alaska does not accept digital signatures or stamps. Not a big deal on this since the applicant needs to write the letter, but something to keep in mind for the future.

Cordially,

*Michelle Johnston*

Alaska State Medical Board (L-Z)  
Division of Corporations, Business & Professional Licensing  
v 907.465.2541  
f 907.465.2974  
<http://www.commerce.state.ak.us/occ/pmed.htm>

---

**From:** Woodard, Marlene [<mailto:wmarlene@med.umich.edu>]  
**Sent:** Tuesday, July 12, 2011 3:04 AM  
**To:** Johnston, Michelle (CED)  
**Subject:** Sarah Wallett

Good morning Michelle:

Attached is the letter of due diligence for Sarah Wallett along with the scanned copy of the receipt from the Ministry of Health/Ghana Health Service documenting that Dr. Wallett obtained a license.

I am mailing out the originals today also for your records. Thank you.



University of Michigan  
Von Volzendorf Women's Hospital

**Marlene Woodard**

Residency Coordinator  
Dept. of Ob/Gyn, University of Michigan, Region 2  
1500 E. Medical Center Drive  
L4510 Women's, SPC 5276  
Ann Arbor, MI 48109-5276  
734.936.9434   
734.232.6020 (fax)

## Johnston, Michelle (CED)

---

**From:** Woodard, Marlene [wmarlene@med.umich.edu]  
**Sent:** Thursday, June 09, 2011 4:39 AM  
**To:** Johnston, Michelle (CED)  
**Subject:** FW: Sarah Wallett

Good morning Michelle:

As you can see from the email below Veridoc does not provide verification for Controlled Substance. Is it possible to verify her controlled substance on the [www.michigan.gov](http://www.michigan.gov) website. In the interim I will begin to process the paperwork with the State of Michigan.



University of Michigan  
Von Voelcker Women's Hospital

### Marlene Woodard

Residency Coordinator  
Dept. of Ob/Gyn, University of Michigan, Region 2  
1500 E. Medical Center Drive  
L4510 Women's, SPC 5276  
Ann Arbor, MI 48109-5276  
734.936.9434 (phone)  
734.232.6020 (fax)

**From:** Veridoc Support [<mailto:jodee@veridoc.org>]  
**Sent:** Wednesday, June 08, 2011 4:38 PM  
**To:** Woodard, Marlene  
**Subject:** re: Sarah Wallett

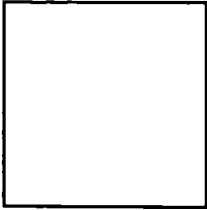
Hi Marlene,

I had not had this request before, so I checked with the MI Board. The board indicated that they do not typically verify controlled substance licenses and they do not provide this information to VeriDoc. Therefore, if you need a controlled substance license verified, you may send a request for verification by to the MI board with a check in the amount of \$15.00.

I am sorry VeriDoc cannot be of assistance.

JoDee S. Wiedmeier  
Operations Manager  
VeriDoc, Inc.  
[jodee@veridoc.org](mailto:jodee@veridoc.org)  
(701) 319-6500

**From:** [wmarlene@med.umich.edu](mailto:wmarlene@med.umich.edu)  
**Sent:** Tuesday, June 07, 2011 6:32 AM  
**To:** [support@veridoc.org](mailto:support@veridoc.org)  
**Subject:** Sarah Wallett



**Sarah Wallett**

Name: Marlene Woodard  
Email: [wmarlene@med.umich.edu](mailto:wmarlene@med.umich.edu)  
Phone: 734.936.9434  
Subject: Sarah Wallett

Question/Comments: A verification was sent for Sarah Wallett for the Alaska State Medical Board in May. The request was for verification of her Michigan license. The State of Alaska Medical Board confirms that verification was sent for her medical license but not her Controlled Substance license. Can you also send that verification to complete the request? Thank you. Marlene Woodard University of Michigan Residency Coordinator 734.936.9434

\*\*\*\*\*  
Electronic Mail is not secure, may not be read every day, and should not be used for urgent or sensitive issues



## Johnston, Michelle (CED)

---

**From:** Woodard, Marlene [wmarlene@med.umich.edu]  
**Sent:** Tuesday, June 07, 2011 8:31 AM  
**To:** Johnston, Michelle (CED)  
**Subject:** RE: Degree Verification Response Regarding Sarah Mary Wallett - Transaction ID# 023078573

Michelle,

I emailed the National Student Clearinghouse and asked them to supply such information. Since I wasn't copied on their email I was unaware what they were going to send and how they were going to send it. I also faxed over the Alaska State Medical Board form to Thomas Jefferson Medical College yesterday and asked them to complete and mail to you.

For clarification sake, does Veridoc mail or electronically send their verification? I also emailed them yesterday and asked them to verify Dr. Wallett's Controlled Substance License. Hopefully this will be received soon.

I contacted ANMC/South Central Foundation and asked them to complete and mail the Acceptance of Responsibility Form to you also. I will contact you closer to July to verify receipt of said items.

Thank you.  
Marlene

---

**From:** Johnston, Michelle (CED) [<mailto:michelle.johnston@alaska.gov>]  
**Sent:** Tuesday, June 07, 2011 11:58 AM  
**To:** Woodard, Marlene  
**Subject:** FW: Degree Verification Response Regarding Sarah Mary Wallett - Transaction ID# 023078573

Marlene,

I received the document from the clearinghouse for Wallett, however as I stated on the phone yesterday, the Alaska State Medical Board does not accept electronic verification. We require a either our form or a letter with an original signature (no stamps or digital signatures accepted) mailed directly from the program stating that the attendee has never been disciplined or placed on probation while in medical school. If a school refuses to do so the physician will not be considered for license/residency.

Cordially,

*Michelle Johnston*

Alaska State Medical Board (L-Z)  
Division of Corporations, Business & Professional Licensing  
v 907.465.2541  
f 907.465.2974  
<http://www.commerce.state.ak.us/occ/pmed.htm>

---

**From:** Colin Hutchison [<mailto:hutchison@studentclearinghouse.org>] **On Behalf Of** DegreeVerify  
**Sent:** Tuesday, June 07, 2011 5:32 AM  
**To:** Johnston, Michelle (CED)  
**Subject:** Degree Verification Response Regarding Sarah Mary Wallett - Transaction ID# 023078573

Good morning Michelle,

We have been asked to provide you with a copy of the verification response provided by Thomas Jefferson University pertaining to the academic record of Sarah Mary Wallett. Please accept the two attached documents, which verify the academic record of Sarah Mary Wallett at Thomas Jefferson University.

Please let us know if you have any questions.

Thank you,

Colin Hutchison  
DegreeVerify Representative II  
National Student Clearinghouse  
[www.degreeverify.org](http://www.degreeverify.org)  
Fax: 703-318-4058

\*\*\*\*\*  
Electronic Mail is not secure, may not be read every day, and should not be used for  
urgent or sensitive issues

**Johnston, Michelle (CED)**

---

**From:** Johnston, Michelle (CED)  
**Sent:** Tuesday, June 07, 2011 7:54 AM  
**To:** 'DegreeVerify'  
**Subject:** RE: Degree Verification Response Regarding Sarah Mary Wallett - Transaction ID# 023078573

Colin,

The Alaska State Medical Board does not accept electronic verification. We require a either our form or a letter with an original signature (no stamps or digital signatures accepted) mailed directly from the program stating that the attendee has never been disciplined or placed on probation while in medical school. If a school refuses to do so the physician will not be considered for license/residency.

Cordially,

*Michelle Johnston*

Alaska State Medical Board (L-Z)  
Division of Corporations, Business & Professional Licensing  
v 907.465.2541  
f 907.465.2974  
<http://www.commerce.state.ak.us/occ/pmed.htm>

---

**From:** Colin Hutchison [<mailto:hutchison@studentclearinghouse.org>] **On Behalf Of** DegreeVerify  
**Sent:** Tuesday, June 07, 2011 5:32 AM  
**To:** Johnston, Michelle (CED)  
**Subject:** Degree Verification Response Regarding Sarah Mary Wallett - Transaction ID# 023078573

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Please let us know if you have any questions.

Thank you,

Colin Hutchison  
DegreeVerify Representative II  
National Student Clearinghouse  
[www.degreeverify.org](http://www.degreeverify.org)  
Fax: 703-318-4058

## Johnston, Michelle (CED)

---

**From:** Johnston, Michelle (CED)  
**Sent:** Tuesday, June 07, 2011 7:58 AM  
**To:** 'wmarlene@med.umich.edu'  
**Subject:** FW: Degree Verification Response Regarding Sarah Mary Wallett - Transaction ID# 023078573

Marlene,

I received the document from the clearinghouse for Wallett, however as I stated on the phone yesterday, the Alaska State Medical Board does not accept electronic verification. We require a either our form or a letter with an original signature (no stamps or digital signatures accepted) mailed directly from the program stating that the attendee has never been disciplined or placed on probation while in medical school. If a school refuses to do so the physician will not be considered for license/residency.

Cordially,

*Michelle Johnston*

Alaska State Medical Board (L-Z)  
Division of Corporations, Business & Professional Licensing  
v 907.465.2541  
f 907.465.2974  
<http://www.commerce.state.ak.us/occ/pmed.htm>

---

**From:** Colin Hutchison [<mailto:hutchison@studentclearinghouse.org>] **On Behalf Of** DegreeVerify  
**Sent:** Tuesday, June 07, 2011 5:32 AM  
**To:** Johnston, Michelle (CED)  
**Subject:** Degree Verification Response Regarding Sarah Mary Wallett - Transaction ID# 023078573

Good morning Michelle,

We have been asked to provide you with a copy of the verification response provided by Thomas Jefferson University pertaining to the academic record of Sarah Mary Wallett. Please accept the two attached documents, which verify the academic record of Sarah Mary Wallett at Thomas Jefferson University.

Please let us know if you have any questions.

Thank you,

Colin Hutchison  
DegreeVerify Representative II  
National Student Clearinghouse  
[www.degreeverify.org](http://www.degreeverify.org)  
Fax: 703-318-4058

# DegreeVerify Certificate

---

**Transaction ID#:** 023078573 **Date Requested:** 05/03/2011 15:10 EST  
**Requested by:** MARLENE WOODARD **Date Notified:** 05/03/2011 15:10 EST  
**Status:** Confirmed  
**Fee:** \$6.50

---

## INFORMATION YOU PROVIDED

**Subject Name:** SARAH MARY WALLETT  
First Name Middle Name Last Name  
**Name Used While Attending School:**  
(if different from above) First Name Middle Name Last Name  
**Date of Birth:** [REDACTED]  
mm/dd/yyyy  
**School Name:** THOMAS JEFFERSON UNIVERSITY  
**Attempt To:** Verify a degree.

---

## INFORMATION VERIFIED

**Name On School's Records:** SARAH MARY WALLETT  
**Date Awarded:** 05/29/2009  
**Degree Title:** DOCTOR OF MEDICINE  
**Official Name of School:** THOMAS JEFFERSON UNIVERSITY  
**School Division:** JEFFERSON MEDICAL COLLEGE  
**Major Course(s) of Study:** MEDICINE 511201  
(and NCES CIP Code, if available):  
**Academic Honors:** SUMMA CUM LAUDE

---

All information verified was obtained directly and exclusively from the individual's educational institution. The Clearinghouse disclaims any responsibility or liability for errors or omissions, including direct, indirect, incidental, special or consequential damages based in contract, tort or any other cause of action, resulting from the use of information supplied by the educational institution and provided by the Clearinghouse. The Clearinghouse also does not verify the accuracy or correctness of any information provided by the requestor.

# DegreeVerify Certificate

**Transaction ID#:** 023078573

**Date Requested:** Yes

**Requested by:** MARLENE WOODARD

**Date Notified:** 05/03/2011 15:10 EST

**Status:** Confirmed

**Fee:** \$6.50

## INFORMATION YOU PROVIDED

<b>Subject Name:</b>	<b>SARAH</b> <small>First Name</small>	<b>MARY</b> <small>Middle Name</small>	<b>WALLETT</b> <small>Last Name</small>
<b>Name Used While Attending School:</b> <small>(if different from above)</small>	 <small>First Name</small>	 <small>Middle Name</small>	 <small>Last Name</small>
<b>Date of Birth:</b>	[REDACTED] <small>mm/dd/yyyy</small>		
<b>School Name:</b>	<b>THOMAS JEFFERSON UNIVERSITY</b>		
<b>Attempt To:</b>	<b>Verify a degree.</b>		

## INFORMATION VERIFIED

**Name:** SARAH M WALLETT  
**Address:** [REDACTED]

This enrollment history reflects all enrollment since 09/17/1997. We do not have enrollment information prior to this date for this school.

Certified by School	Enrolled	Term Start	Term End	School Name
06/08/2009	Yes	01/05/2009	05/22/2009	THOMAS JEFFERSON UNIVERSITY MEDICAL
12/16/2008	Yes	07/07/2008	12/19/2008	THOMAS JEFFERSON UNIVERSITY MEDICAL
06/09/2008	Yes	01/07/2008	06/20/2008	THOMAS JEFFERSON UNIVERSITY MEDICAL
12/12/2007	Yes	07/09/2007	12/21/2007	THOMAS JEFFERSON UNIVERSITY MEDICAL
06/05/2007	Yes	01/02/2007	05/11/2007	THOMAS JEFFERSON UNIVERSITY MEDICAL
12/28/2006	Yes	08/21/2006	12/15/2006	THOMAS JEFFERSON UNIVERSITY MEDICAL
06/12/2006	Yes	01/03/2006	06/06/2006	THOMAS JEFFERSON UNIVERSITY MEDICAL
12/13/2005	Yes	08/08/2005	12/16/2005	THOMAS JEFFERSON UNIVERSITY MEDICAL

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**Johnston, Michelle (CED)**

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**From:** Woodard, Marlene [wmarlene@med.umich.edu]  
**Sent:** Monday, June 06, 2011 11:10 AM  
**To:** 'service@studentclearinghouse.org'; 'transcripts@studentclearinghouse.org'  
**Cc:** Johnston, Michelle (CED)  
**Subject:** Transaction ID# 023078573 (Sarah Wallett)

To Whom It May Concern:

**Transaction ID# 023078573**

My University of Michigan Ob/Gyn resident Sarah Wallett needs verification of her Thomas Jefferson Medical School to obtain a Alaska State Medical License. We applied online for the verification and were issued a transaction ID # but the Alaska State Medical Board has yet to receive her verification of Medical School.

The information has to come directly from the verification source which is National Student Clearinghouse. Is it possible to email verification to Michelle Johnston at the State Medical Board?

Her telephone number is 907.465.2541 and her email is: [michelle.johnston@alaska.gov](mailto:michelle.johnston@alaska.gov)

**Marlene Woodard**

Residency Coordinator  
Dept. of Ob/Gyn, University of Michigan, Region 2  
1500 E. Medical Center Drive  
L4510 Women's, SPC 5276  
Ann Arbor, MI 48109-5276  
734.936.9434 (phone)  
734.232.6020 (fax)

**Marlene Woodard**

Residency Coordinator  
Dept. of Ob/Gyn, University of Michigan, Region 2  
1500 E. Medical Center Drive  
L4510 Women's, SPC 5276  
Ann Arbor, MI 48109-5276  
734.936.9434 (phone)  
734.232.6020 (fax)

\*\*\*\*\*  
Electronic Mail is not secure, may not be read every day, and should not be used for urgent or sensitive issues

**STATE OF ALASKA**  
**DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT**  
**DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING**  
**STATE MEDICAL BOARD**  
**P.O. BOX 110806**  
**JUNEAU, ALASKA 99811-0806**  
**Website: [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ)**

Dr Sarah M Wallet  
1500 E medical Center Dr  
SPC 5276  
Ann Arbor, MI 48109

Date: May 31, 2011

Your application for residency permit to allow you to practice medicine and surgery in the State of Alaska has been received by the Alaska State Medical Board. This office will not guarantee processing of last minute requests for resident permits.

- Your file is complete and has been approved for the resident permit. Your start date is  
Your permit will be mailed on
- Your file has been forwarded for further review to the board's Executive Administrator. Processing is  
continuing.
- Your file is incomplete and you must submit the following:
  - 1. Complete application
  - 2. Authorization to Release Records Form
  - 3. Certified true copy of your medical school diploma (notary must state "true copy of the  
original," sign, and seal) or official transcripts directly from the school
  - 4. Letter from your internship or residency program
  - 5. Letter from Alaska institution accepting responsibility for training
  - 6. Verification of Medical School Education
  - 7. Verification of Licensure from any jurisdiction where you have ever been licensed as a Health  
Care Professional
  - 8. Clearance Report from the Federation of State Medical Boards
  - 9. Residency nonrefundable application and permit fee of \$50.00

Additional Comments: The copy of the diploma is not properly certified as it omits the word original. Please see enclosed instructions.

Need verification of license from Ghana and the MI controlled substance license

Please remember it is your responsibility to keep this office advised of your current mailing address at all times. If you have any questions, please do not hesitate to call this office at (907) 465-2541 or email, [michelle.johnston@alaska.gov](mailto:michelle.johnston@alaska.gov)

Michelle Johnston, Licensing Examiner  
State Medical Board



JENNIFER M. GRANHOLM  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH L2003717

BOARD OF MEDICINE  
PHYSICIAN  
EDUCATIONAL LIMITED  
LICENSE EFFECTIVE 06/16/2009

\*LICENSE IS VALID ONLY AT SITE AND PROGRAM STATED BELOW  
\*UNIVERSITY OF MI HEALTH SYSTEM - OB/GYN

SARAH MARY WALLETT  
L4510 WOMENS  
1500 E MEDICAL CENTER DRIVE  
SPC 5276  
ANN ARBOR MI 48109

PERMANENT I.D. NO.

EXPIRATION DATE

4301094048

06/30/2012

2863173

THIS DOCUMENT IS DULY ISSUED  
UNDER THE LAWS OF THE STATE  
OF MICHIGAN.

JENNIFER M. GRANHOLM  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH L2003873

BOARD OF PHARMACY  
CONTROLLED SUBSTANCE LICENSE

\*THIS LICENSE VALID ONLY IF PROFESSIONAL LICENSE IS ACTIVE

SARAH MARY WALLETT

PERMANENT I.D. NO.

EXPIRATION DATE



06/30/2012

2862815

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UNDER THE LAWS OF THE STATE  
OF MICHIGAN.

**RECEIVED  
JUNEAU**

**MAY 23 2011**

Division of Corporations, Business  
and Professional Licensing

# DegreeVerify Certificate

Transaction ID#: 023078573

Date Requested: Yes

Requested by: MARLENE WOODARD

Date Notified: 05/03/2011 15:10 EST

Status: Confirmed

Fee: \$6.50

## INFORMATION YOU PROVIDED

**Subject Name:** SARAH MARY WALLETT  
First Name Middle Name Last Name

**Name Used While Attending School:** (if different from above)  
First Name Middle Name Last Name

**Date of Birth:** [REDACTED]  
mm/dd/yyyy

**School Name:** THOMAS JEFFERSON UNIVERSITY  
**Attempt To:** Verify a degree.

## INFORMATION VERIFIED

**Name:** SARAH M WALLETT  
**Address:** [REDACTED]

This enrollment history reflects all enrollment since 09/17/1997. We do not have enrollment information prior to this date for this school.

Certified by School	Enrolled	Term Start	Term End	School Name
06/08/2009	Yes	01/05/2009	05/22/2009	THOMAS JEFFERSON UNIVERSITY MEDICAL
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06/09/2008	Yes	01/07/2008	06/20/2008	THOMAS JEFFERSON UNIVERSITY MEDICAL
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06/05/2007	Yes	01/02/2007	05/11/2007	THOMAS JEFFERSON UNIVERSITY MEDICAL
12/28/2006	Yes	08/21/2006	12/15/2006	THOMAS JEFFERSON UNIVERSITY MEDICAL
06/12/2006	Yes	01/03/2006	06/06/2006	THOMAS JEFFERSON UNIVERSITY MEDICAL
12/13/2005	Yes	08/08/2005	12/16/2005	THOMAS JEFFERSON UNIVERSITY MEDICAL

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**MAY 23 2011**

Division of Corporations, Business  
and Professional Licensing

Dup



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MAY 11 2011

JENNIFER M. GRANHOLM  
Governor

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

ANCHORAGE  
ALASKA STATE MEDICAL BOARD  
JANET OLSZEWSKI  
Director

**VERIFICATION OF LICENSURE  
MICHIGAN BOARD OF MEDICINE  
VERIFICATION OF LICENSURE AS OF 05/11/2011**

**NAME:** Sarah Mary Wallett **BIRTHDATE:** [REDACTED]  
**ADDRESS:** L4510 Womens  
1500 E Medical Center Drive  
Ann Arbor MI 481095276  
**TYPE:** Medical Doctor - Educational Limited **ORIGINAL DATE:** 06/16/2009  
**LICENSE NUMBER:** 4301094048 **STATUS:** Active **EXPIRATION DATE:** 06/30/2012  
**OBTAINED BY:** Application

EXAM DATE                      EXAM TYPE                                      EXAM SCORE OR RESULT

DISCIPLINARY ACTION                      NONE

OPEN FORMAL COMPLAINTS                      NONE

This license information was last updated on. 05/11/2011

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**MAY 17 2011**

Division of Corporations, Business  
and Professional Licensing

**Patredis, Miriam (CED)**

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**From:** support@veridoc.org  
**Sent:** Wednesday, May 11, 2011 7:56 AM  
**To:** Patredis, Miriam (CED)  
**Subject:** License Verification Statement - Wallett, Sarah  
**Attachments:** v82018AA.pdf



**Verification of Licensure Status**

The attached verification report has been sent to you by the VeriDoc.org website. This email can be verified as coming from this site by clicking on the link below.

[Validate Verifications](#)

Physician: Wallett, Sarah

Transaction ID: 82018

Confirmation Number: 14511919324921794318

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**MAY 17 2011**

Division of Corporations, Business  
and Professional Licensing



**OMNIBUS HAS LITERAS VISITIS**  
**SARAE WALLET.**

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

**VOTUM SIT, QUOD NOS. PRAESES ET PROFESSORES**  
**Collegii Medicinalis Jeffersoniani Philadelphiensis**  
**Universitatis Thomasiae Jeffersonianae**  
**IN REPUBLICA PENNSYLVANIENSIS.**

**Sarah Mary Wallett**

*Hominem probum, nobis devotissimum propter mores benevolos et omnes eas artes, quae optimum quemque ornant, qui etiam scientia, eximia in Arte Medica, aequae 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 Sarah Mary Wallett 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, **HEC MEMBRANA**, Chirographis nostris subscripta, et Sigillo Universitatis nostrae munita, testimonio sit.*

Datum, in **URBE, PHILADELPHIA.**

vicesimo nono die Mai Anno Humanae Salutis **MMIX** Annoque  
 Rerum Publicarum Americae Foederatum Summae Potestatis anno ducentesimo tricesimo tertio.

*A. S. L.*  
**PRAESES.**

*M. T. C. M. C. I.*  
**DECANUS, PRO PROFESSORIBUS.**



*True & certified copy of  
 Medical School diploma  
 Marlene Woodard*

Omits word original

**RECEIVED  
JUNEAU**

**MAY 23 2011**

Division of Corporations, Business  
and Professional Licensing



**Johnston, Michelle (CED)**

---

**From:** Johnston, Michelle (CED)  
**Sent:** Friday, July 22, 2011 4:00 PM  
**To:** 'swallet@med.umich.edu'  
**Subject:** Alaska resident permit

Dr Wallet,

This is to inform you that your Alaska resident permit has been issued and is being mailed out this afternoon. The permit number is 6172 and is valid from 8/1/11-8/29/11.

Cordially,

*Michelle Johnston*

Alaska State Medical Board (L-Z)  
Division of Corporations, Business & Professional Licensing  
v 907.465.2541  
f 907.465.2974  
<http://www.commerce.state.ak.us/occ/pmed.htm>

No. 6172

Effective: 08/01/2011

Expires: 08/29/2011

# STATE OF ALASKA

DEPARTMENT OF COMMERCE, COMMUNITY, & ECONOMIC DEVELOPMENT

Division of Corporations, Business and Professional Licensing

## STATE MEDICAL BOARD

Certifies that

# SARAH MARY WALLETT

IS A PHYSICIAN

## IN A RESIDENCY PROGRAM

Commissioner: Susan K. Bell

RESIDENT PROGRAM AT ANMC  
VALID ONLY FROM 8/01/11 TO 8/29/2011

Wallet Card

No. 6172

State Of Alaska

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing

**SARAH MARY WALLETT**

IS A PHYSICIAN  
IN A RESIDENCY PROGRAM

Effective	Expiration	Date of Birth
08/01/2011	08/29/2011	08/31/1983

RESIDENT PROGRAM AT ANMC  
VALID ONLY FROM 8/01/11 TO 8/29/201

Signature \_\_\_\_\_

MED

SARAH MARY WALLETT  
1500 E MEDICAL CENTER DR SPC 5276  
WOMEN'S HOSPITAL FL 4 RM L4510  
ANN ARBOR MI 48109

**ALASKA STATE MEDICAL BOARD**

**CHECKLIST - RESIDENT PERMIT**

**APPLICANT INFORMATION**

Revised:  By:

Applicant  
 Last Name:  First:  Middle:  Prof. Desig.   
 (MD/DO/DPM)

Medical School:  Year Graduated:

Fees: Application & Permit Fee  Receipt No.  Date Paid:

**APPLICATION DOCUMENTS**

**Date Rec'd Document**

- Application, w/ Photo/Notary
- Auth. for Release of Records
- Medical School Diploma
- Verification from Med School
- Residency Program Verification
- Acceptance of Responsibility from Alaska Facility  
 Name and Address of Facility:
- Verifications of Licensure as Physician:
- Verifications of Licensure as Other Health Care Provider:  
 Type of License: \_\_\_\_\_  
 Type of License: \_\_\_\_\_
- FSMB Board Action Data Bank Report

**RECEIVED**  
 JUL 21 2011  
 Transcript:   
 Accredited:   
 ANCHORAGE  
 ALASKA STATE MEDICAL BOARD

**Processing Notes**

Mailed from medical school with verification

Alaska Native Medical Center  
 4315 Diplomacy Drive  
 Anchorage, AK 99508  
 Start Date:

State  Rec'd  State  Rec'd   
 State  Rec'd  State  Rec'd

State  Rec'd  State  Rec'd   
 State  Rec'd  State  Rec'd

Irregularities:

App Status Letters Sent - Date(s):

State Documents: \_\_\_\_\_

App Complete - Sent to Administrator  
 Prepared by Licensing Examiner

**Board Member/Designee Review for Issuance of Resident Permit:**

Interview Required (Yes  No) Reason for Interview: \_\_\_\_\_

Approved for Issuance of Resident Permit  Denied - to be considered by full board

Comments:

Signature: Debrae Stover   
 Date