STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

BOARD OF MEDICAL EXAMINERS
ANN M. MARTINO, PHD., EXECUTIVE DIRECTOR

August 10, 1997

Thomas W. Ross, D.O.
[redacted]

Dear Doctor Ross:

Your application for permanent Iowa medical license has undergone a preliminary review in the offices of the Iowa State Board of Medical Examiners. The review indicated the following information is needed before further review of your application can be made:

1. NBOME exam scores.

2. An explanation of your activities from 7/91 to the present.

When the above information has been received a second review of your license application will be made. Please feel free to write or call this office if you have any questions. Calls regarding license applications are answered from **2:00 p.m. to 4:00 p.m.** Monday through Friday.

Sincerely,

Gregory A. Kise
Information Specialist

cc: File
Enclosure(s)

Licensure Checklist

Physician's Name: Thomas W. Ross, D.O.

DATE FILED AND INITIAL:		1ST Review	2ND Review
_____	Application Fee Received	✓	OK
_____	Application Sections Complete Comments:	✓	OK
_____	Chronology Comments: Incomplete – last ends 7/91	~~✓~~	OK
_____	Section 12 Questions	✓	OK
_____	Application notarized with photo	✓	OK
7-29/Rcw	Malpractice Action	✓	OK
_____	Certification of Medical Education	✓	OK
_____	~~AMA~~ AOA Physician Profile Comments:	✓	OK
7.29 Rcw	Discipline Inquiries from Federation	✓	OK applic. pg
X	License verifications from: I.A. – renewal look-up 6/24/97 app.	—	—
_____	Notarized copy of IA license	✓	OK
_____	Notarized copy of medical diploma UDMHS 5/96	✓	OK
_____	Notarized translation of diploma	—	n/a
_____	Residency/Internship certificate	✓	OK
_____	Notarized copy of ECFMG certificate N/A	N/A	n/a
_____	Verification from ECFMG N/A	N/A	n/a
_____	Notarized copy of specialty board certificate N/A	N/A	n/a
X	Exam scores for: NBME	8/18	OK
_____	Authorization for Release of Personal Information	✓	OK
_____	Post-graduate training verification from: Des Moines Gen. Hosp. 6/96 – 6/97	✓	OK
_____	Hospital privilege verification from: N/A	N/A	n/a
_____	Other/Comments	—	—

03819

IOWA STATE BOARD OF MEDICAL EXAMINERS

RESIDENT PHYSICIAN'S APPLICATION FOR LICENSURE

READ INSTRUCTIONS ON PAGE 3.
COMPLETE CENTER PORTION OF PAGE 4.

April 9, 1996
(Date)

'96 APR 15 PM 4:10 $50
IA. BOARD OF MED. EXAMINERS

To the Iowa State Board of Medical Examiners:

I hereby make application for a license to practice as a Resident Physician in the State of Iowa and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

(Name must coincide with medical diploma)

THIS APPLICATION MUST BE TYPEWRITTEN!

1. Name Thomas (First) William (Middle) Ross (Last)
2. Addresses [redacted] (Home address) (County)
3. Place of Birth [redacted] (Place) Date of Birth [redacted] (Month) (Day) Age [redacted]
4. Name and address (Father) [redacted]
5. Name and address (Mother) [redacted]
6. Are you a citizen of the United States? Yes If not, give particulars
7. Identification: Height [redacted] Weight [redacted] Color of Hair [redacted]
   Color of Eyes [redacted] Identifying marks [redacted]

8. PRELIMINARY EDUCATION (Beginning with High School. Give name of institutions attended and location, with concise statement of periods of study.)

   High School John Marshall H.S. Rochester, MN 55901 (Name, location, dates of attendance) graduated 5/74

   College Mankato State University Mankato, MN Comm.Hlth. (Name, location, dates of attendance) graduated B.S 6/86

   Academic Degree of A.A. from Rochester Comm. College on 6/78 (Date)

   Please see attached information

9. MEDICAL EDUCATION

   I have spent five years in the study of medicine, each year

   comprising twelve (Months) each, in the following institutions.

	(Name and location of college)	from (Month)	(Year)	to (Month)	(Year)
Freshman	U.O.M.H.S.	9	1991	7	1992
Sophomore	U.O.M.H.S.	8	1992	7	1993
Junior	U.O.M.H.S.	8	1993	8	1994
Senior	U.O.M.H.S.	8	1994	8	1995
	U.O.M.H.S.	8	1995	8	1996

   I was granted the degree of Doctor of Osteopathic Medicine by U.O.M.H.S. (Name of institution)

   located at Des Moines, IA, on the 31 day of May, 1996

   A photostatic copy of my diploma is submitted herewith. (Photostat must not be larger than 8 x 10 in. or smaller than 6 x 8 in.)

10. POST GRADUATE TRAINING, INCLUDING RESIDENCIES AND INTERNSHIPS

    NA (Name) (Location)
    from ..... 19 ..... to ..... 19 .....

    (Name) (Location)
    from ..... 19 ..... to ..... 19 .....

    (Name) (Location)
    from ..... 19 ..... to ..... 19 .....

11. STATES AND COUNTRIES IN WHICH YOU ARE LICENSED: NA

    State ..... License No. ..... Date ..... How obtained ..... (Exam. or End.)

    State ..... License No. ..... Date ..... How obtained ..... (Exam. or End.)

    State ..... License No. ..... Date ..... How obtained ..... (Exam. or End.)

12. ANSWER ALL QUESTIONS. IF THE ANSWER TO ANY QUESTION IS YES AND NOT FULLY ANSWERED BELOW, GIVE DETAILS IN A NOTARIZED AFFIDAVIT ATTACHED TO THE APPLICATION.

A. Name states and/or foreign countries in which you have practiced and length of time in each. NA

B. Where do you intend to reside in the state of Iowa? Greater Des Moines

C. What type of resident training do you propose to follow? Family Practice
Where? Des Moines General Hospital
(Name and Location of Institution)

D. List hospital staff positions (Give address and dates of service). NA

E. Have you ever been denied Staff Membership in any hospital? No

F. Have you ever been warned or censured by, or requested to withdraw from any hospital in which you have trained, been a staff member, or held hospital privileges? No

G. Are you a member of any medical society? If so, give particulars: No

H. Have you ever been notified, or requested to appear before any Medical Society in regard to charges or complaints filed against you? No Have you ever been rejected by a Medical Society? No

I. Have you ever failed to pass any State Medical or Osteopathic Board Examination, National Board or FLEX examination? [redacted] If so, where and how many times? [redacted]

J. Have you ever been denied a certificate by, or the privilege of taking an examination before any State Medical Board? No Have you ever been notified by, or requested to appear before any State Medical Board in regard to charges or complaints filed against you? No Has any State Medical Board suspended or revoked a license it had granted you? No

K. Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or habit-forming drugs? No

L. Are you now or have you ever been emotionally or mentally ill? No Have you ever received psychotherapy? No Have you ever been a patient (voluntarily or otherwise) in any institution for the treatment of mental or emotional illness, drug addiction, or alcohol problems? No Have you ever been treated, but not hospitalized for mental or emotional illness, drug addiction, or alcohol problems? No

M. Have you ever been convicted of a felony? No A misdemeanor? Petty-Traffic Have any judgments ever been entered against you? No Have you ever been sued for malpractice? No Please see attached information.

N. Do you understand that if the license asked for is granted by this Board, it will be on the truth of the statements contained herein, which if false, will subject you to criminal prosecution, and revocation of the said license certificate? Yes

13. AFFIDAVIT OF APPLICANT

State of Iowa
County of Polk ss.

I, Thomas W. Ross, being duly sworn state, under penalty of perjury, that the foregoing information contained in this application and any attachments are true and correct, and that the attached photograph is a true likeness of myself.

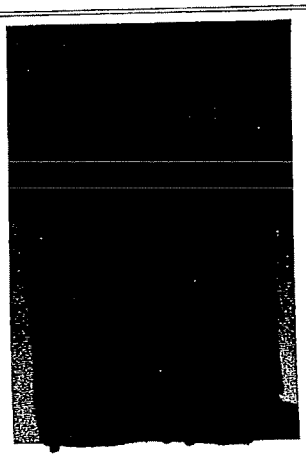
Thomas W. Ross
(Signature of Applicant)

Sworn to before me this 9 day of April
19 96, Penny Parker
(Notary Public)

My Commission expires 4/5/98

PENNY PARKER
MY COMMISSION EXPIRES
APRIL 5, 1998

(S E A L)



NOTE: This Board cannot require you to attach a recent photograph on this application. However, in the absence of a photograph, please furnish this Board with notarized photostatic copies of your birth certificate and driver's license.

RECOMMENDATION OF SUPERINTENDENT OF HOSPITAL

I, Gregory L. Ingle, DO Interim DME, superintendent of the Des Moines General hospital, at 603 E 12th STreet Des Moines, IA 50309 certify that Doctor Thomas Ross will be employed by this institution as a resident physician beginning 6/24/96 (Date)

I further certify that Doctor Ross to the best of my knowledge and belief is a person of good moral and professional character and qualified to practice as a resident physician in the State of Iowa. I have carefully examined all the statements made by the applicant and believe them to be true in every respect. I also certify that the photograph attached to this application is a recent one and a true likeness of said Doctor Ross.

I hereby recommend Doctor Ross to the Iowa State Board of Medical Examiners as a fit and proper person to receive a license to practice as a resident physician in the State of Iowa.

Date 4/11/96

(Superintendent of Hospital)

INSTRUCTIONS

1. Application must be TYPEWRITTEN and filled out in every detail and returned to the Executive Director, Iowa State Board of Medical Examiners, State Capitol Complex, Executive Hills West, Des Moines, Iowa 50319.

2. Application must be accompanied by:

   (a) Fee of $50 (personal checks on United States banks). APPLICATION FEES ARE NOT REFUNDABLE.

   (b) Notarized photostatic copy of medical diploma.

   (c) Notarized photostatic copy of E.C.F.M.G., if foreign medical graduate.

   (d) English translation must accompany foreign credentials.

THIS APPLICATION AND THE DOCUMENTS FILED HEREIN ARE NONTRANSFERRABLE AND CANNOT BE USED FOR ANY OTHER APPLICATION FOR LICENSURE.

DO NOT FILL THE BLANKS BELOW

Certificate No. DR 0272

Book No. R Page 414

Certificate Issued 6-24 , 19 96

IOWA STATE BOARD OF
MEDICAL EXAMINERS

RESIDENT PHYSICIAN'S APPLICATION FOR LICENSURE

Name .....

.....

Residence .....

.....

County of .....

State of .....

Filed ..... , 19 .....

Fee Paid ..... , 19 .....

Diploma Verified ..... , 19 .....

By .....

Returned by .....

Examined ..... , 19 .....

General Average .....

Re-examined ..... , 19 .....

General Average .....

APPLICANT MUST FILL FOLLOWING BLANKS

Name Thomas William Ross

Present Address [redacted]

[redacted]

Age [redacted]

Date - Place of Birth [redacted]

Applicants Social Security

[redacted]

Name of College Issuing Diploma U.O.M.H.S.

Located at Des Moines, IA

Date of Graduation May 31 , 19 96

School of Practice Osteopathic Medicine

RESIDENT PHYSICIAN'S LICENSE LAW

Any physician, who is a graduate of a medical school and is serving only as a resident physician and who is not licensed to practice medicine and surgery in this state, shall be required to obtain from the medical examiners a license to practice as a resident physician. The license shall be designated "Resident Physician", and shall authorize the licensee to serve as a resident only, under the supervision of a licensed practitioner of medicine and surgery, in an institution approved for this purpose by the medical examiners. Such license shall be valid for one year and may be annually renewed at the discretion of the medical examiners. The fee for this license shall be fifty dollars, and if extended beyond one year, an annual renewal fee of ten dollars per year shall be required. The medical examiners shall determine in each instance those eligible for this license, whether or not examinations shall be given, and the type of examinations. No requirements of the law pertaining to regular permanent licensure shall be mandatory for this resident licensure except as specifically designated by the medical examiners. The granting of a resident physician's license does not in any way indicate that the person so licensed is necessarily eligible for regular licensure, nor are the medical examiners in any way obligated to so license such individual. The medical examiners shall revoke said license at any time they shall determine either that the caliber of work done by a licensee or the type of supervision being given such licensee does not conform to reasonable standards established by the medical examiners.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

BOARD OF MEDICAL EXAMINERS
ANN M. MARTINO, PHD., EXECUTIVE DIRECTOR

July 9, 1996

Glenda Shannon
Des Moines General Hosp/Medical Educa. Dept.
603 East 12th Street
Des Moines, IA 50309

Dear Glenda Shannon:

This is a letter of confirmation informing you that Thomas W. Ross, DO has been issued resident license number DO-R-0272 to practice Family Practice within the Des Moines General Hospital Internship on June 24, 1996.

Licenses are valid for a period of one year from the date of issuance and valid only for the resident/internship program at your facility.

The certificates will be mailed separately.

If you have any questions, please contact this office.

Sincerely,
ANN M. MARTINO, Ph.D.
EXECUTIVE DIRECTOR

Julia Fox

By: Julia Fox, License Section

cc: Pharmacy Board and File

University of Osteopathic Medicine and Health Sciences

upon recommendation of the faculty of the

College of Osteopathic Medicine and Surgery

and by the authority of the State of Iowa
hereby confers upon

Thomas W. Ross

the degree of

Doctor of Osteopathic Medicine

with all the honors, rights and privileges thereunto appertaining,
in recognition of the satisfactory completion of the requirements for this degree.
In witness whereof the Board of Trustees has caused the seal of the University
to be affixed at Des Moines, Iowa, this thirty-first day of May, 1996.

Paul Peter Kruzan
President of the University

Joseph Wallach, M.D., D.O. FACGP
Dean of the College

UNIVERSITY OF OSTEOPATHIC MEDICINE & HEALTH SCIENCES · 1898 ·

Chairman of the Board

J. P. McTierney D.O.
Secretary of the Board

TIMOTHY A. MUNSON
MY COMMISSION EXPIRES
6/23/98

Timothy A. Munson

Employment History for Thomas W. Ross

1.	JCPenny Co. Rochester, MN 55901	11/73 - 10/74 Bicycle Mechanic
2.	Mazeppa Police Department Mazeppa, MN	1/75 - 8/76 Internship
3.	Dodge Center Police Dept. Dodge Center, MN	11/76 - 5/78 Police Officer
4.	Owatonna Ambulance Service Owatonna, MN	6/78 - 4/81 ✓ President/General Manager
5.	Gold Cross Ambulance Rochester, MN 55901	4/81 - 8/83 ✓ Paramedic/Training Coord.
6.	Gold Cross Ambulance Mankato, MN 56001	11/83 - 10/86 Paramedic
7.	Medcenter One Hospital Bismarck, ND 58501	10/86 -6/91 ✓ EMS Ed. Coordinator

I certify the above as accurate 5/13/96

PENNY PARKER
MY COMMISSION EXPIRES
APRIL 5,1998

Penny Parker
5/13/96

96 MAY 15 PM 1:28
IA. BOARD OF MED. EXAMINERS

ADDENDUM FOR ITEM EIGHT - PRELIMINARY EDUCATION FOR
Thomas W. Ross

1.	John Marshall High School Rochester, MN 55901	9/71 - 5/74
2.	Rochester Community College Rochester, MN 55901	9/74 - 6/78 Associate of Arts
3.	Mankato State University Mankato, MN 56001	9/83 - 6/86 Bachelor of Science
4.	Bismarck State College Bismarck, ND 58501	9/89 - 6/91 Pre-med.
5.	University of Mary Bismarck, ND 58501	6/91 - 7/91 Pre-med.

Other:

A.	Basic Police Science Course Anoka, MN	9/77 - 11/77 Certified Police Officer
B.	Owatonna Advanced Life Support Program Owatonna, MN	10/79 - 5/80 Certified Paramedic

5/13/96

I certify the above as accurate

NOTARIAL SEAL IOWA
PENNY PARKER
MY COMMISSION EXPIRES
APRIL 5,1998

Penny Parker
5/13/96

96 MAY 15 PM 1:20
IA. BOARD OF TECH. EXAMINERS

American Osteopathic Association
142 E. ONTARIO STREET • CHICAGO, ILLINOIS 60611
1-800-621-1773 or (312) 280-5800

PROFILE SERVICE

PHYSICIAN'S ADDRESS:

65520-1
Thomas W Ross
[redacted]

REQUESTING INSTITUTION:

IA State Board of Medical Exam
Executive Hills West
1209 E Court Ave
Des Moines, IA 50319

DOB: [redacted]

Date: 04/18/96

MEDICAL EDUCATION:
Univ of Osteo Med & Health Sci, Des Moines, IA - Graduated, 1996

HEALTH PROFESSIONAL ACTIVITY:
Student

PRACTICE FOCUS:
Major: Unknown

STATE LICENSURE:
Unknown

AOA MEMBERSHIP STATUS:
Member

96 APR 22 PM 12:27
IA BOARD OF MEDICAL EXAMINERS

PLEASE COMPLETE AND MAIL TO THE FEDERATION AT THE ADDRESS SHOWN BELOW

96 MAY -2 AM 11:51

IA. BOARD OF MED. EXAMINERS

DISCIPLINARY INQUIRIES
FEDERATION OF STATE MEDICAL BOARDS
400 FULLER WISER ROAD
EULESS, TX 76039

APR 15 1996

The **IOWA BOARD OF MEDICAL EXAMINERS** requests a disciplinary search concerning the following individual:

Thomas W. Ross
NAME.

[redacted]
ADDRESS

[redacted]
CITY, STATE AND ZIP CODE

[redacted]
DATE OF BIRTH

[redacted]
SOCIAL SECURITY NUMBER

U. O. M. H. S. – Des Moines
MEDICAL SCHOOL OF GRADUATION AND BRANCH LOCATION

5/31/96
DATE OF GRADUATION

FEDERATION WILL MAIL RESPONSE TO:

IOWA STATE BOARD OF MEDICAL EXAMINERS
EXECUTIVE HILLS WEST - ATTN: RESIDENT LICENSURE
1209 E. COURT AVENUE
DES MOINES, IOWA 50319-0180

Thomas Ross
(PHYSICIAN SIGNATURE)

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

APR 25 1996

James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

Additional information pertaining to item M:

I have averaged about one speeding ticket per year for the past ten years. I only have specific data regarding the last two citations - 1. Speeding 70 mph in 55 mph zone, Polk County, 3/28/96 2. Speeding 87 mph in a 65 mph zone, Iowa County, 11/19/95.

I should add I have had no accidents during that period and I have never had a traffic ticket for anything other than speeding.

Thomas W. Ross

Sworn to before me this 10th day of April, 1996

Penny Parker

PENNY PARKER
MY COMMISSION EXPIRES
APRIL 5,1998

96 APR 15 PM 4:15
IA. BOARD OF MED. EXAMINERS

RESIDENT LICENSURE APPLICANT

96 APR 15 PM 4:15
IA. BOARD OF MED. EXAMINERS

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I Thomas W. Ross, do hereby authorize a full disclosure of all records concerning myself to any duly authorized agent of the Iowa State Board of Medical Examiners, whether the said records are of a public, private or confidential nature.

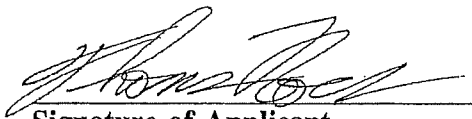
The intent of this authorization is to give my consent for full and complete disclosure of records of state, territorial, or national medical or osteopathic licensing agencies or boards, educational institutions; medical and psychiatric treatment and/or consultation, including hospitals, clinics, private practitioners, and the U.S. Veteran's Administration; employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me and records of any actions either criminal or civil, in which I presently have, or have had involvement, including arrest and criminal history records. This release also includes information concerning hospital staff membership or privileges, internship and/or residency records as well as records of hospitals, clinics, private physicians offices, attorneys and insurance companies regarding professional liability or malpractice claims and/or lawsuits.

I understand that any information obtained by a personal history background investigation which is developed directly or indirectly, in whole or in part, upon this release authorization will be considered in determining my suitability for a license to practice in the State of Iowa. I also certify that any person(s) who may furnish such information concerning me shall not be held accountable for giving this information; and I do hereby release said person(s) from any and all liability which may be incurred as a result of furnishing such information. I further release the Iowa State Board of Medical Examiners from any and all liability which may be incurred as a result of collecting such information.

A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

This release authorization is non-expiring and shall continue in force and effect indefinitely.

I have read and fully understand the contents of this "Authorization for Release of Personal Information"



Signature of Applicant 3/12/96 **DATE**

[redacted] 4-7-96

Witness **DATE**

THOMAS WILLIAM ROSS

[redacted]

96 APR 15 PM 4:15

IA. BOARD OF MED. EXAMINERS

EDUCATION: Doctor of Osteopathic Medicine
University of Osteopathic Medicine and Health Science, Des Moines, Iowa. Expected graduation in May of 1986.

Bachelor of Science Degree, Major in Community Health, Minor in Criminal Justice. Graduated in June of 1986 from Mankato State University Mankato, Minnesota

Paramedic Training Program, National Standard Curriculum, Certifed in May of 1980 from Owatonna Advanced Life Support Program Owatonna, Minnesota

Associate of Arts Degree, Major in Law Enforcement, Minor in Sociology, Graduated in June of 1978 from Rochester Community College Rochester, Minnesota

Basic Police Science Course, Minnesota Department of Public Safety, completed November 1977

EMPLOYMENT: Medcenter One Hospital in Bismarck, North Dakota Position: EMS Education Coordinator Role: Director of paramedic and other EMS educational programs including ACLS, PALS, and CPR for both public and regional health care providers, October 1986 - June 1991

Mankato State University, Emergency Medical Care and Rescue Program, in Mankato, Minnesota Position: Adjunct Health Science Instructor Role: Instructor for paramedic and EMT courses, March 1984 - October 1986

Gold Cross Ambulance in Mankato, Minnesota Position: Senior Paramedic Role: Emergency and non-emergency patient care and transportation, vehicle operation and maintenance, November 1983 - October 1986

Gold Cross Ambulance in Rochester, Minnesota Position: Paramedic/dispatcher promoted to Training Coordinator Role: Responsible for all continuing education, EMT courses at community college, and outreach courses for surrounding volunteer EMS providers, April 1981 - August 1983

Owatonna Ambulance Service in Owatonna, Minnesota Position: President and General Manager Role: Organized, implemented, and managed new private ambulance service initially at the BLS level, upgraded to ALS, ~~April 1981~~ June 1978 - August 1983 March 1981

Dodge Center Police Department in Dodge Center, Minnesota Position: Patrolman promoted to Sargeant Role: Uniformed patrol, investigation, juvenile officer, also served as team leader on volunteer ambulance squad, November 1976 - May 1978

RELATED EXPERIENCE: Dakota Affiliate of the American Heart Association Board of Directors member and Affiliate Faculty from 1988 until 1991

South Central Minnesota EMS Joint Powers Board at Mankato, Minnesota Position: Intern Role: This internship involved communications and training, including developing a multiple victim incident workshop with accompaning video program during the period from January to July 1986 and continued as a consultant

Ross Life Support Programs in Owatonna and Rochester, Minnesota was an enterprise to provide EMT-Intermediate training to volunteer EMS sites arround the state. This was a pilot course and the first EMT-I course licensed by Minnesota Department of Health. Six courses conducted from 1980 until 1983

Steele County Sheriff's Office in Owatonna, Minnesota serving as a special deputy on a volunteer basis from October 1979 until March 1981

Mazeppa Police Department in Mazeppa, Minnesota as a police officer, initially as an internship, asked to continue as an an interim full-time officer until Sheriff's Office could assume coverage, January 1974 August 1975

PROFESSIONAL LICENSURE: Iowa Board of Medical Examiners certified paramedic, P99-500-06, July 1991

North Dakota Board of Medical Examiners licensed paramedic, November 1986

Minnesota Department of Health certified paramedic, July 1980

National Registered Emergency Medical Technician-Paramedic, MP802295, July 1980

Minnesota Board of Peace Officers licensed police officer, 9216, August 1986

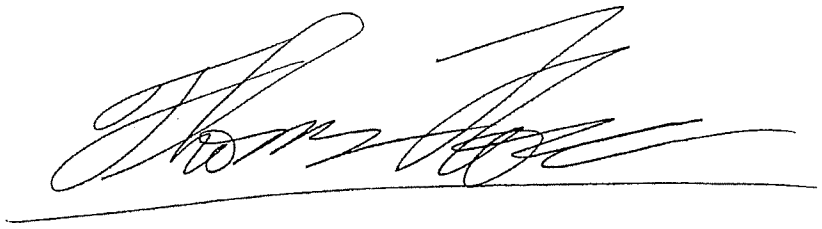
INSTRUCTOR STATUS: American Heart Association Basic Life Support Instructor-Trainer (1976), Advanced Cardiac Life Support (1984) and Pediatric Advanced Life Support (1989) Instructor

American College of Emergency Physicians Basic Trauma Life Support Instructor (1988)

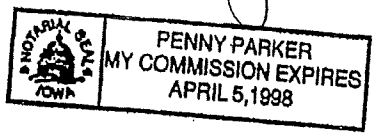
American College of Surgeons Prehospital Trauma Life Support Instructor (1987)

AWARDS: Department commendation for public service from the City of Dodge Center, Minnesota in May of 1977

Minnesota Association of Emergency Medical Technicians "EMT of the Year" for 1982



Sworn to before me this 10th day of April, 1996



Application for Permanent Iowa Medical License

Iowa State Board of Medical Examiners

1209 E. Court Avenue ★ Executive Hills West ★ Des Moines, IA 50319-0180

INSTRUCTIONS TO APPLICANT

1. Read the accompanying "Instructions for completing Application for Permanent Iowa Medical License" before completing this application.
2. Application should be Typewritten. Each question must be answered and the application must be **notarized.**
3. *Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.*
4. The application fee is not refundable. Applications are valid for 120 days from date of receipt. After 120 days a re-activation fee must be paid.
5. For questions in Section 12, attach a detailed, signed explanation for any "Yes" answer.

1. IDENTIFYING INFORMATION

Full Legal Name: (Last, First, Middle, Suffix)	Ross, Thomas William		
Other Names Used:	none		
Street Address:	[redacted]		
City: [redacted]	County: [redacted]	State: [redacted]	Zip: [redacted]
Work Address:	Des Moines General Hospital 603 E. 12th St.		
City: Des Moines	County: Polk	State: IA	Zip: 50309
Home Phone: [redacted]	Work Phone: (515) 263-4200		
Social Security Number: [redacted]	U.S. Citizen? ☒ Yes ☐ No	If No, Visa Type or Alien Registration Number:	
Identification Height: [redacted]	Weight: [redacted]	Hair Color: [redacted]	Eye Color: [redacted]
Identifying Marks: [redacted]			

2. BIRTH INFORMATION

Date of Birth: [redacted]	City of Birth: [redacted]	State of Birth: [redacted]	Country of Birth: USA
Father's Full Name: [redacted]		Mother's Full Name: [redacted]	
Full Name & Address of Nearest Relative Not Living With You: [redacted]			

3. BASIS FOR APPLICATION

- ☐ FLEX Examination, Iowa, Date(s): .....
- ☐ FLEX Examination, State: .....
- ☒ National Board of Osteopathic Medical Examiners Examination (NBOME)
- ☐ National Board of Medical Examiners Examination (NBME)
- ☐ State Board Examination, State .....
- ☐ Licentiate of Medical Council of Canada Examination (LMCC)
- ☐ United States Medical Licensing Examination (USMLE)
- ☐ Combination FLEX, NBME, NBOME, or USMLE

4. PRELIMINARY EDUCATION

Name of High School:	City, State:		From (Mo, Yr):	To (Mo, Yr):
John Marshall	Rochester, MN		9/71	5/74
Name of College:	**City, State:**	**Degree:**	**From (Mo, Yr):**	**To (Mo, Yr):**
Rochester Community College	Rochester, MN	A.A.	9/74	6/78
Name of College:	**City, State:**	**Degree:**	**From (Mo, Yr):**	**To (Mo, Yr):**
Mankato State University	Mankato, MN	B.S.	9/83	6/86

5. MEDICAL EDUCATION

INSTITUTION	City, State, Country	From (Mo, Yr):	To (Mo, Yr):
Year 1 UOMHS	Des Moines, IA	8/92	6/93
Year 2 UOMHS	Des Moines, IA	7/93	7/94
Year 3 UOMHS	Des Moines, IA	8/94	7/95
Year 4 UOMHS	Des Moines, IA	8/95	7/95
Year 5 UOMHS	DEs Moines, IA	8/95	5/96

Degree Received: D.O.

Date of Degree: 5/96

A notarized copy of my diploma is submitted herewith. I further state that I am the identical person to whom this diploma was granted, that the same was procured in the regular course of study without fraud or misrepresentation, and that the copy presented is a true copy.
For more space to complete Section 5, attach a separate sheet of paper, labeled "Section 5" and signed by you.

6. POST-GRADUATE MEDICAL TRAINING

Name of Facility:	From (Mo, Yr):	To (Mo, Yr):
Des Moines General Hospital	6/96	6/97
Address:	**City:**	**State/Providence:**
603 E. 12th St.	Des Moines	IA

Type of Training: ☒ Intern ☐ Resident ☐ Fellow ☐ Other (Be Specific).....

Enclose a notarized copy of internship/residency certificate(s).

Name of Facility:	From (Mo, Yr):	To (Mo, Yr):
Address:	**City:**	**State/Providence:**

Type of Training: ☐ Intern ☒ Resident ☐ Fellow ☐ Other (Be Specific).....

Name of Facility:	From (Mo, Yr):	To (Mo, Yr):
Address:	**City:**	**State/Providence:**

Type of Training: ☐ Intern ☐ Resident ☐ Fellow ☐ Other (Be Specific).....

Name of Facility:	From (Mo, Yr):	To (Mo, Yr):
Address:	**City:**	**State/Providence:**

Type of Training: ☐ Intern ☐ Resident ☐ Fellow ☐ Other (Be Specific).....

7. CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all medical and non-medical activities from the date of your graduation from high school to the present date, with no more than a three month gap in time. Include months, years, location (city and state), and exact nature of each activity. Attach additional sheets of paper, labeled with your name and signed by you, if necessary.

ACTIVITY	From (Mo, Yr)	To (Mo, Yr)
Please see the enclosedlists (2) for preliminary		
education and employment history.		

8. HOSPITAL AFFILIATIONS

List all hospitals (other than training hospitals) at which you have had staff privileges. Attach a separate sheet if necessary.

Hospital Name	Address	From (Mo, Yr)	To (Mo, Yr)
N/A			

9. LICENSE INFORMATION

List all states/countries in which you are or have ever been licensed.

State/Country	License No.	Date Issued	License Type (i.e. Training, Permanent)	How Obtained (i.e. Endorsement, Exam)
IA	00-R-0272	6-24-96	resident	

10. PRACTICE INFORMATION

Type of Practice You are Currently Involved In (Check all that Apply):

☐ Intern ☐ Fellowship ☒ Resident ☐ Private ☐ Partnership ☐ Corporation ☐ Faculty ☐ H.M.O.

☐ Other (Please Explain) ▸

Proposed Iowa Practice Address (If Unknown,Please Explain): (Institution/Group, Street, City, State, Zip)

Des Moines General Hospital 603 E.12th St. Des Moines, IA 50309

Specialty ▸ Family Practice

Type of Practice You will be Involved in if Iowa License is Granted (Check all that Apply):

☐ Intern ☐ Fellowship ☒ Resident ☐ Private ☐ Partnership ☐ Corporation ☐ Faculty ☐ H.M.O.

☐ Other (Please Explain) ▸

Specialty Board Certifications	Date Certified
1. N/A	1.
2.	2.

Enclose a notarized copy of all specialty board certificates.

11. EXAMINATION INFORMATION

Have you taken the National Board Medical/Osteopathic Examination? ☒ Yes ☐ No

No. of Times.....1..... Status: ☒ Pending ☐ Diplomate

Have you taken the FLEX Examination/USMLE Examination? ☐ Yes ☒ No Number of Times.....

Date(s), State(s) and Specific Exam for All FLEX/USMLE Exams:.....

Have you taken a State Board Examination? ☐ Yes ☒ No Number of Times.....

Dates & States of All State Board Exams.....

Have you taken the SPEX Examination within the last ten (10) years? ☐ Yes ☒ No

If Yes, Date..... State..... Results.....

Have you taken the Educational Commission for Foreign Medical Graduates (ECFMG) Examination? ☐ Yes ☒ No

Certificate Number..... Date Issued..... Valid Through.....

(Enclose a notarized copy of current ECFMG certificate.)

Definitions for Section 12.

Important! Read these definitions before completing Section 12!

"**Ability to practice medicine with reasonable skill and safety**" means all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses, to exercise reasoned medical judgments, and to learn and keep abreast of medical developments;

2. The ability to communicate medical judgements and information to patients and other health care providers; and

3. The capability to perform medical tasks such as physical examinations and surgical procedures, with or without the use of aids or devices.

"**Medical condition**" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"**Chemical substances**" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"**Currently**" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two years.

"**Improper use of drugs or other chemical substances**" means all of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and

2. The use of any substance, including, but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"**Illegal use of drugs or other chemical substances**" means the manufacture, possession, distribution, or use of any chemical substance prohibited by law (e.g. heroin).

SECTION 12. In answering each of the following questions, please check the appropriate box next to each question. FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).

YES	NO	
☐	☒	1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
☐	☒	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
☐	☒	3. Does your current use of alcohol, drugs, or other chemical substances in any way impair or limit your ability to practice medicine with reasonable skill and safety?
☐	☒	4. Are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
☐	☒	5. Does your field of practice, the setting, or the manner in which you have chosen to practice medicine, reduce or eliminate the limitations or impairments caused by your medical condition or use of alcohol, drugs, or other chemical substances?

SECTION 12. In answering each of the following questions, please check the appropriate box next to each question. FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).

YES	NO		
☐	☒	6.	Have you ever been charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime (other than minor traffic violations with fines under $100)?
☐	☒	7.	Have you ever been terminated or requested to withdraw from any medical school or training program?
☐	☒	8.	Have you ever been requested to repeat a portion of an internship, residency or fellowship program?
☐	☒	9.	Have you ever received a warning, reprimand, or been placed on probation during an internship, residency, or fellowship program?
☐	☒	10.	Have you ever been denied a license to practice medicine?
☐	☒	11.	Have you ever voluntarily surrendered a license issued to you by any medical/osteopathic licensing agency?
☐	☒	11a.	If yes, was a license disciplinary action pending against you, or were you under investigation by a medical/osteopathic licensing agency, at the time the voluntary surrender of license was tendered?
☐	☒	12.	Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?
☐	☒	13.	Have you ever surrendered your state or federal controlled substances registration or had it restricted in any way?
☐	☒	14.	Aside from ordinary initial requirements of proctorship, have your clinical privileges or medical staff status at any hospital or health care entity, nursing facility, clinic, or other professional health care organization ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?
☐	☒	15.	Has your specialty board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced?
☐	☒	16.	Have you ever been denied membership or renewal thereof, or been subject to any disciplinary action, sanction, or warning in any medical or osteopathic organization or professional society?
☐	☒	17.	Have you ever been terminated, sanctioned, penalized, had to repay monies to, or been denied provider participation in any state Medicaid, federal Medicare, or other publicly funded healthcare program?
☐	☒	18.	Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?
☐	☒	19.	Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?
☐	☒	20.	Have you ever been investigated or subject to an inquiry/review by any medical/osteopathic licensing agency, including investigations or reviews which resulted in no formal action(s)? (Answer "Yes" if you have ever been contacted by an investigator or Board agent to review a complaint or report filed against you.)
☐	☒	21.	Have any professional liability suits or claims ever been filed against you?
☐	☒	22.	Have any judgements or settlements been paid on your behalf as a result of a professional liability case(s)?
☒	☐	23.	Do you understand that if a license is granted by this Board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the license?

14. AFFIDAVIT OF APPLICANT

State of Iowa

County of Polk

I, Thomas Ross, hereby swear or affirm, under penalty of perjury, that I am the person described and identified; that the attached photo is a true likeness of myself; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby certify that I have fully read and understood all instructions sent with this application. I also certify that I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I declare under penalty of perjury that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license to practice medicine in Iowa. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

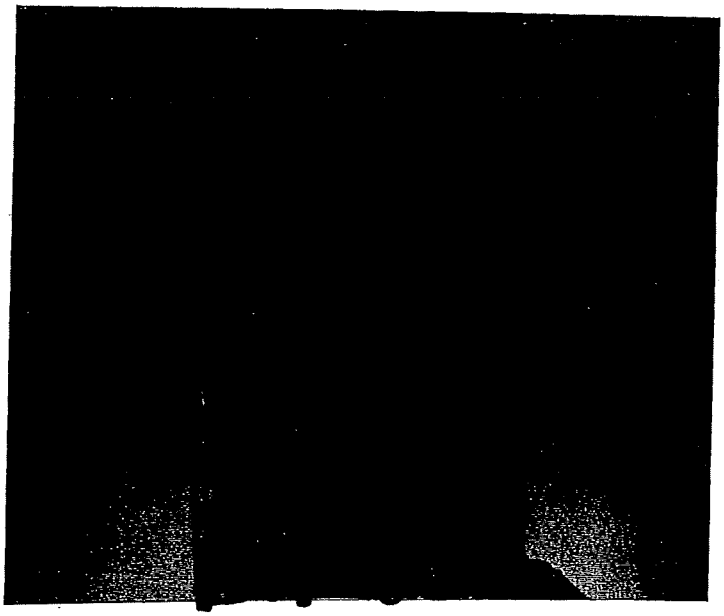
Signature of Applicant

NOTARIAL SEAL IOWA
PAUL J. UHL
MY COMMISSION EXPIRES
7-26-98

Sworn/Affirmed to before me on 7-17 19 97

Signature of Notary Public

My commission Expires: 7-26-98



Applicant - Please Complete: Address For License and Future Renewals

Mail License and all Board Correspondence to:

Street Address.....

.....

City.....

County.....

State..... Zip.....

For Board Use Only - Do Not Write Below This Line

Application Received .....

Application Valid Through .....

1st Review .....

2nd Review .....

Fee Received $.....

License # 3119

Date Issued 3119 9-3-97

Issued based on N BOME

Book 7 Page 2013

License Mailed to:

Name Thomas William Ross, D.O.

Address Des Moines General Hospital

603 E. 12th St.

City Des Moines

State IA Zip 50309

County Polk

Approved by JE OK

Medical School Univ. of Osteopathic Med + Health Sci.

State/Country Des Moines, IA

Date of Diploma 5-31-96

Comments: No Spec

Exp: 6-1-98

IA. BOARD OF MED. EXAMINERS

97 JUL 21 PM 1:31

7-11-97

STATE OF IOWA
TERRY E. BRANSTAD, GOVERNOR

BOARD OF MEDICAL EXAMINERS
ANN M. MARTINO, PHD., EXECUTIVE DIRECTOR

September 4, 1997

Thomas William Ross, D.O.
603 E. 12th Street
Des Moines, IA 50309

RE: MEDICINE AND OSTEOPATHIC SURGERY LICENSURE

Dear Dr. Ross:

This is a letter of confirmation informing you that you have been issued license number 3119 with an effective date of September 3, 1997, authorizing you to practice osteopathic medicine and surgery in the state of Iowa.

The "original license" will be mailed to the above address within two to three weeks.

Every practitioner who administers, prescribes, or dispenses any controlled substance must be registered under both state and federal controlled substances acts. For more information, contact the Iowa Board of Pharmacy Examiners at (515) 281-5944.

Please contact this office should you need further verification, or have a change of address.

Sincerely,
Ann M. Martino, Ph.D.
Executive Director

Judy Ireland

BY: Judy Ireland
Administrative Assistant, Licensure Section

cc: File

NOTICE:
This license will expire on June 1, 1998. A renewal notice will be mailed to you 60 days prior to the expiration date. Please be aware that the renewal fee must be paid immediately.

(Seal)

7/21

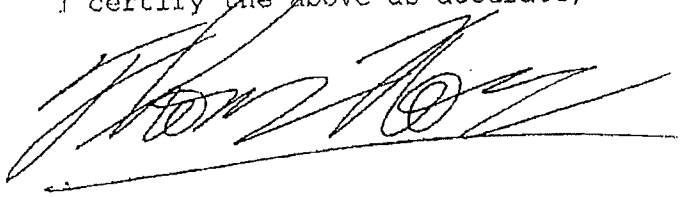
PRELIMINARY EDUCATION FOR
Thomas W. Ross

1.	John Marshall High School Rochester, MN 55901	9/71 - 5/74
2.	Rochester Community College Rochester, MN 55901	9/74 - 6/78 Associate of Arts
3.	Mankato State University Mankato, MN 56001	9/83 - 6/86 Bachelor of Science
4.	Bismarck State College Bismarck, ND 58501	9/89 - 6/91 Pre-med.
5.	University of Mary Bismarck, ND 58501	6/91 - 7/91 Pre-med.
6.	University of Osteopathic Medicine & Health Science Des Moines, IA 585801	8/91 - 5/96 D.O.
7.	Des Moines General Hospital Des Moines, IA 50309	6/96 - 6/97 Internship

Other:

A.	Basic Police Science Course Anoka, MN	9/77 - 11/77 Certified Police Officer
B.	Owatonna Advanced Life Support Program Owatonna, MN	10/79 - 5/80 Certified Paramedic

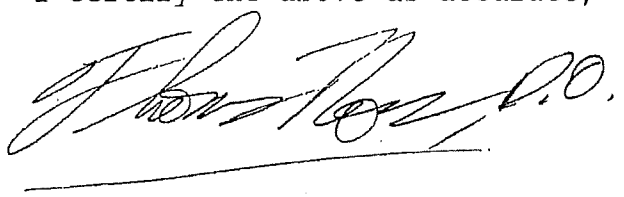
I certify the above as accurate,



Employment History for Thomas W. Ross

1.	JCPenny Co. Rochester, MN 55901	11/73 - 10/74 Bicycle Mechanic
2.	Mazeppa Police Department Mazeppa, MN	1/75 - 8/76 Internship
3.	Dodge Center Police Dept. Dodge Center, MN	11/76 - 5/78 Police Officer
4.	Owatonna Ambulance Service Owatonna, MN	6/78 - 4/81 President/General Manager
5.	Gold Cross Ambulance Rochester, MN 55901	4/81 - 8/83 Paramedic/Training Coord.
6.	Gold Cross Ambulance Mankato, MN 56001	11/83 - 10/86 Paramedic
7.	Medcenter One Hospital Bismarck, ND 58501	10/86 -6/91 EMS Ed. Coordinator

I certify the above as accurate,



PRELIMINARY EDUCATION FOR
Thomas W. Ross

1. John Marshall High School Rochester, MN 55901	9/71 - 5/74
2. Rochester Community College Rochester, MN 55901	9/74 - 6/78 Associate of Arts
3. Mankato State University Mankato, MN 56001	9/83 - 6/86 Bachelor of Science
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5. University of Mary Bismarck, ND 58501	6/91 - 7/91 Pre-med.

Other:

A. Basic Police Science Course Anoka, MN	9/77 - 11/77 Certified Police Officer
B. Owatonna Advanced Life Support Program Owatonna, MN	10/79 - 5/80 Certified Paramedic

I certify the above as accurate,

J. Thomas Ross D.O.

No Ag.

American Osteopathic Association
142 E. ONTARIO STREET • CHICAGO, ILLINOIS 60611
1-800-621-1773 or (312) 280-5800

CORRECTED PROFILE

No app

PROFILE SERVICE

PHYSICIAN'S ADDRESS:

65520-1
Thomas W Ross DO
[redacted]

DATE OF BIRTH: [redacted]

REQUESTING INSTITUTION:

IA State Board of Medical Ex
Executive Hills West
1209 E Court Ave
Des Moines, IA 50319

Date: 07/10/97

MEDICAL EDUCATION:
Univ of Osteo Med & Health Sci, Des Moines, IA - Graduated: 1996

POSTDOCTORAL TRAINING:

Des Moines General Hospital	Des Moines, IA	06/24/1996-06/23/1997 INTERNSHIP
Des Moines General Hospital	Des Moines, IA	06/01/1997-02/31/1999 RESIDENCY Family Practice

MAJOR PROFESSIONAL ACTIVITY:
Postdoctoral Training

PRACTICE FOCUS:
Major: Family Practice Minor: Unknown

STATE LICENSURE:
Unknown

AOA MEMBERSHIP STATUS:
Member

97 JUL 17 PM 1:12
IA. BOARD OF MED. EXAMINERS

1-21

IOWA BOARD OF MEDICAL EXAMINERS

1209 E. Court Ave ★ Executive Hills West ★ Des Moines, IA 50319-0180 ★ (515) 281-5171

JUL 1997 RECEIVED

Attach photo here

CERTIFICATION OF MEDICAL EDUCATION

As part of the medical license application process, the Iowa Board of Medical Examiners requires that this form be completed by the school at which the applicant received his/her medical education. The applicant should attach a recent photo to this form, and complete the top portion of the form only. The completed form must be mailed directly from the medical school to the **IOWA BOARD OF MEDICAL EXAMINERS**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name Thomas Ross, D.O. SS# [redacted]

Signature Thomas Ross, D.O. Date 7/13/97

Dates of Attendance: 1991 - 1996

****

IT IS HEREBY CERTIFIED THAT: Thomas W. Ross
(Name of Applicant)

RECEIVED MEDICAL EDUCATION AT: Univ of Osteopathic Med & Health Sciences
(Name of School)

LOCATED AT: 3200 Grand Avenue, Des Moines, Iowa 50312
(Full Address of School)

FROM (month, year): Aug. 1991 **TO (month, year):** May 1996

And was granted a Diploma with the Degree of DOCTOR OF OSTEOPATHY

Date Diploma Received: May 31, 19 96

Attached photograph is a true likeness? Yes XX **No*** _____

Any derogatory information on file? Yes* _____ **No** XX

IA. BOARD OF MED. EXAMINERS
97 JUL 25 PM 2:55

President, Dean, Secretary or Registrar:

Print Name Kathy L. Scaglione

Signature Kathy L. Scaglione

Title Registrar

Date July 22, 1997
(Month, Day, Year)

Phone No. (515) 271-1460

School Seal**

*PLEASE ATTACH LETTER OF EXPLANATION AND SUPPORTING DOCUMENTATION.
**IF THERE IS NO SEAL, ATTACH LETTER OF EXPLANATION ON LETTERHEAD.

CEN: 588-0193

No. **DO-R-0272**

State of Iowa

Resident Osteopathic Physician and Surgeon License

Iowa State Board of Medical Examiners
Hereby Authorizes and Licenses

Thomas W. Ross, DO

to practice as a Resident Osteopathic Physician and Surgeon in the State of Iowa under and pursuant to the provisions of Chapter one hundred and fifty A, Iowa Statutes Annotated and acts amendatory thereof and supplemental thereto.

This certificate shall be limited to one year and may be renewed from year to year. Valid only to practice at the Des Moines General Hospital Internship residency program in Family Practice.

BOARD OF MEDICAL EXAMINERS STATE OF IOWA

Issued at Des Moines, Iowa June 24, 1996.

NOTARIAL SEAL IOWA
PAUL J. UHL
MY COMMISSION EXPIRES
7-26-97

IA. BOARD OF MED. EXAMINERS
97 JUL 21 PM 3:41

Executive Director

University of Osteopathic Medicine and Health Sciences

97 JUL 21 PM 3:41
IA. BOARD OF MED. EXAMINERS

upon recommendation of the faculty of the

College of Osteopathic Medicine and Surgery

and by the authority of the State of Iowa
hereby confers upon

Thomas W. Ross

the degree of

Doctor of Osteopathic Medicine

with all the honors, rights and privileges thereunto appertaining,
in recognition of the satisfactory completion of the requirements for this degree.
In witness whereof the Board of Trustees has caused the seal of the University
to be affixed at Des Moines, Iowa, this thirty-first day of May, 1996.

Paul Peter Kruzan DO
President of the University

Joseph Walsh, PA. D., DO. FACGP
Dean of the College

UNIVERSITY of OSTEOPATHIC MEDICINE & HEALTH SCIENCES • 1898 •

Chairman of the Board

Secretary of the Board

TIMOTHY A. MUNSON
MY COMMISSION EXPIRES
6/25/97

Des Moines General Hospital

Osteopathic
Des Moines, Iowa
This Certifies That

THOMAS W. ROSS, D.O.

has fulfilled the internship program
requirements during the period

June 24, 1996 through June 23, 1997

(ROTATING)

In Witness Whereof the said Hospital has caused this Certificate to be signed by its duly authorized officers and its Official Seal to be hereunto affixed.

Chairman of the Board

Chief Executive Officer

Director of Medical Education

IA. BOARD OF MED. EXAMINERS
97 JUL 21 PM 3:41

Des Moines General Hospital

Osteopathic
Des Moines, Iowa
This Certifies That

THOMAS W. ROSS, D.O.

has fulfilled the internship program requirements during the period

June 24, 1996 through June 23, 1997

(ROTATING)

In Witness Whereof the said Hospital has caused this Certificate to be signed by its duly authorized officers and its Official Seal to be hereunto affixed.

Chairman of the Board

Chief Executive Officer

Director of Medical Education

No App.

County of Polk
State of Iowa

I hereby certify that this is a true and exact copy of the original document.

Glenda D. Shannon
Notary
My commission expires October 13, 1997.

GLENDA D. SHANNON
MY COMMISSION EXPIRES
10-13-97

Des Moines General Hospital

"Better At What Matters"

FAX TRANSMISSION COVER LETTER

Date 7-1-97

TO: Judy Fax #: 242-5908

Title/Department:

Company: Iowa Board

FROM: Glenda Shannon

Title/Department: Med. Ed

3 Page(s) Including This Page

Comments: Copy of certificate for Tom Ross, DO

If receipt of the inclusive pages is not recognized, please call (515) 263 - 4794 for assistance with incomplete transmission. Glenda

603 East Twelfth Street · Des Moines, Iowa 50309 · (515) 263-4200 · FAX: (515) 263-4699

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I Thomas Ross, D.O., do hereby authorize a full disclosure of all records concerning myself to any duly authorized agent of the Iowa State Board of Medical Examiners, whether the said records are of a public, private or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of records of state, territorial, or national medical or osteopathic licensing agencies or boards, educational institutions; medical and psychiatric treatment and/or consultation, including hospitals, clinics, private practitioners, and the U.S. Veteran's Administration; employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me and records of any actions either criminal or civil, in which I presently have, or have had involvement, including arrest and criminal history records. This release also includes information concerning hospital staff membership or privileges, internship and/or residency records as well as records of hospitals, clinics, private physicians offices, attorneys and insurance companies regarding professional liability or malpractice claims and/or lawsuits.

I understand that any information obtained by a personal history background investigation which is developed directly or indirectly, in whole or in part, upon this release authorization will be considered in determining my suitability for a license to practice in the State of Iowa. I also certify that any person(s) who may furnish such information concerning me shall not be held accountable for giving this information; and I do hereby release said person(s) from any and all liability which may be incurred as a result of furnishing such information. I further release the Iowa State Board of Medical Examiners from any and all liability which may be incurred as a result of collecting such information.

A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

This release authorization is non-expiring and shall continue in force and effect indefinitely.

I have read and fully understand the contents of this "Authorization for Release of Personal Information"

Thomas Ross, D.O. 7/13/97

Signature of Applicant **DATE**

[redacted]

Witness [redacted] 7-13-97

DATE

CFN: 588-9184

7/21/9

IOWA BOARD OF MEDICAL EXAMINERS

1209 East Court Avenue ★ Executive Hills West ★ Des Moines, IA 50319 ★ (515) 281-5171

POST-GRADUATE TRAINING VERIFICATION

As part of the medical license application process, the Iowa Board of Medical Examiners requires that this form be completed by an official of each program/facility in which the applicant enrolled for post-graduate internship, residency or fellowship training. The completed form must be mailed directly by each facility to the **IOWA BOARD OF MEDICAL EXAMINERS.** Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name Thomas Ross, D.O. **SS#** [redacted]

Signature Thomas Ross, D.O. **Date** 7/13/97

****

IT IS HEREBY CERTIFIED THAT: Thomas Ross DO
(Name of Applicant)

RECEIVED POST-GRADUATE TRAINING AT: Des Moines General Hospital
(NAME OF PROGRAM/FACILITY)

LOCATED AT: 603 E 12th St. Des Moines IA 50309
(Address)

From: 6-24-96 **To:** 6-23-97
(Month, Date, Year) (Month, Date, Year)

Type of Training Program Rotating internship **No. of Years Required** 1

Did applicant satisfactorily complete all required years of the post-graduate training program? Yes ✓ **No*** _____

Any Disciplinary Action? Yes* ____ **No** ✓

Any Derogatory Information on File? Yes* ____ **No** ✓

97 JUL 31 AM 11:57
IA. BOARD OF MED. EXAMINERS

Seal**

Print Name Gregory L. Ingle, DO

X Signature _____

Title Interim DME

Date 7-18-97
(Month, Date, Year)

Phone No. [redacted]

*PLEASE ATTACH LETTER OF EXPLANATION AND SUPPORTING DOCUMENTATION.
**IF THERE IS NO SEAL, ATTACH LETTER OF EXPLANATION ON LETTERHEAD.

CFN: 588-9190

Des Moines General Hospital

"Better At What Matters"

FAX TRANSMISSION COVER LETTER

Date 7-29-97

TO: Judy Fax #: [redacted]

Title/Department:

Company: IA Board of Examiners

FROM: Glenda Shannon

Title/Department: Med Ed

2 Page(s) Including This Page

Comments: Original will be mailed.

If receipt of the inclusive pages is not recognized, please call (515) [redacted] for assistance with incomplete transmission.

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