STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

APP-SENT 4/9/91

PLEASE TYPE OR PRINT CLEARLY

I hereby submit the following information in order to receive an application for licensure:

NAME: Webb, Chandra Yvette
LAST (Surname) FIRST MIDDLE SUFFIX (Jr.,II)

ADDRESS: 2255 Winter Pkwy, #98 Cuyahoga Falls, OH 44221 USA
STREET & NUMBER CITY STATE ZIP COUNTRY

TELEPHONE: BUSINESS: (216) 375-3000 HOME: (216) 945-4007
AREA CODE & NUMBER AREA CODE & NUMBER

BIRTH DATE: 10/ 06/ 62 BIRTH PLACE: Atlanta, Georgia USA
MO/DAY/YR CITY STATE COUNTRY

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: Morehouse School of Medicine 720 Westview Dr., S.W. Atlanta, GA 30310 USA
SCHOOL NAME STREET ADDRESS CITY STATE COUNTRY

7 / / 85 5 / / 89 MD 5 / / 89
FROM: MO/DAY/YR TO: MO/DAY/YR DEGREE RECEIVED DATE RECEIVED: MO/DAY/YR

OTHER MEDICAL SCHOOLS ATTENDED: (IF "NONE ENTER "NONE")
None
SCHOOL NAME STREET ADDRESS CITY STATE COUNTRY

/ / / /
FROM: MO/DAY/YR TO: MO/DAY/YR REASON EDUCATION NOT COMPLETED AT THIS SCHOOL

SCHOOL NAME STREET ADDRESS CITY STATE COUNTRY

/ / / /
FROM: MO/DAY/YR TO: MO/DAY/YR REASON EDUCATION NOT COMPLETED AT THIS SCHOOL

E.C.F.M.G. CERTIFICATE: YES _____ NO N/A NUMBER _____ DATE ISSUED / /

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: None AFFILIATED WITH: _____
(IF "NONE", ENTER "NONE") HOSPITAL OR INSTITUTION NAME OF MEDICAL SCHOOL

ADDRESS: _____ DATE: / / / /
STREET & NUMBER CITY STATE ZIP FROM TO

QUALIFYING EXAM TAKEN: _____ DATE: / /

POSTGRADUATE TRAINING

LIST ALL POSTGRADUATE TRAINING (INTERNSHIP, RESIDENCY OR CLINICAL FELLOWSHIP), UNDERTAKEN IN THE U.S. OR CANADA. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

HOSPITAL: Univ of South Alabama 2451 Fillingim St. Mobile, Alabama
NAME STREET ADDRESS CITY STATE
POSITION: PGY-1 & 2 DEPARTMENT: OB/GYN DATE: 7 / 89 2 /91
FROM: MO/YR TO: MO/YR

HOSPITAL: Akron City Hospital 75 Arch St. Akron Ohio
NAME STREET ADDRESS CITY STATE
POSITION: PGY-2 DEPARTMENT: OB/GYN DATE: 3 / 91 present
FROM: MO/YR TO: MO/YR

HOSPITAL: _____
NAME STREET ADDRESS CITY STATE
POSITION: _____ DEPARTMENT: _____ DATE: / /
FROM: MO/YR TO: MO/YR

HOSPITAL: _____
NAME STREET ADDRESS CITY STATE
POSITION: _____ DEPARTMENT: _____ DATE: / /
FROM: MO/YR TO: MO/YR

LICENSES IN OTHER COUNTRIES

LIST ALL FOREIGN COUNTRIES IN WHICH YOU HOLD OR HAVE HELD A FULL RIGHT TO PRACTICE MEDICINE AND SURGERY. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

COUNTRY: N/A ISSUE DATE: / / LICENSE # CURRENT: YES NO

COUNTRY ISSUE DATE: / / LICENSE # CURRENT: YES NO

LICENSES IN THE UNITED STATES

LIST ALL STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY. INDICATE THE LICENSE NUMBER, DATE OF ISSUANCE, WHETHER OR NOT THE LICENSE IS CURRENT, AND THE BASIS OF LICENSURE (E.G., FLEX EXAM, ENDORSEMENT OF OTHER STATE LICENSE, ENDORSEMENT OF DIPLOMATE STATUS, ETC.) IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: Alabama ISSUE DATE: 9 / / 90 LICENSE #: 15511 CURRENT: YES X NO

BASIS OF LICENSURE: To practice medicine in the state of Alabama

STATE: ISSUE DATE: / / LICENSE #: CURRENT: YES NO

BASIS OF LICENSURE:

STATE: ISSUE DATE: / / LICENSE #: CURRENT: YES NO

BASIS OF LICENSURE:

STATE BOARD OR FLEX EXAMINATIONS TAKEN

LIST EACH AND EVERY STATE BOARD OR FLEX EXAM WHICH YOU HAVE TAKEN WHETHER IN OHIO OR ANY OTHER STATE, TERRITORY OR PROVINCE. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: Georgia DATE TAKEN: June 1987 PASS: X FAIL: FULL ( ) PARTIAL ( )

STATE: Georgia DATE TAKEN: Sept 1988 PASS: X FAIL: FULL ( ) PARTIAL ( )

STATE: Alabama DATE TAKEN: March 1990 PASS: X FAIL: FULL ( ) PARTIAL ( )

ADDITIONAL ELIGIBILITY INFORMATION -- ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? PENDING YES X NO DATE 6/90

DIPLOMATE OF THE NATL BOARD OF OSTEO MEDICAL EXAMINERS? PENDING YES NO X DATE /

ARE YOU APPLYING TO SIT FOR THE FLEX EXAM IN OHIO? YES NO X

A LICENTIATE OF THE MEDICAL COUNSEL OF CANADA? YES NO X DATE / /

A U.S. CITIZEN? YES NO BASIS OF CITIZENSHIP DATE: / /

A GRADUATE OF A MEXICAN MEDICAL SCHOOL? YES NO X DATE / /

DEGREE OBTAINED (CHECK ONLY ONE): ACTA TITULO MEDICO CIRUJANO

HAVE YOU ACHIEVED A SCORE OF AT LEAST TWO HUNDRED THIRTY (230) ON THE TEST OF SPOKEN ENGLISH OF THE EDUCATIONAL TESTING SERVICE AS REQUIRED UNDER SECTION 4731.09, O.R.C.? (THE TOEFL, ECFMG EXAM, etc., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TSE) YES NO

N/A

OHIO RESIDENT AT THE TIME OF ADMISSION TO MEDICAL SCHOOL? YES NO X

IF YES, GIVE FULL ADDRESS AT THAT TIME:

STREET ADDRESS CITY STATE ZIP

CERTIFICATION

I, Chandra Y. Webb, HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING REQUEST FOR APPLICATION FORM; THAT THE STATEMENTS THEREIN ARE STRICTLY TRUE IN EVERY RESPECT AND THAT I HAVE READ AND UNDERSTAND THIS CERTIFICATION.

Chandra Y. Webb March 26, 1991

SIGNATURE DATE

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

APPLICATION FOR MEDICAL & OSTEOPATHIC LICENSURE

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

ALL RESPONSES MUST BE TYPED

1. SOCIAL SECURITY NUMBER: Redacted

2. FULL NAME (Use no initials)

LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
Webb,	Chandra	Yvette	

3. NAME (As you prefer it inscribed on your Ohio license)

LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
Webb,	Chandra	Y.	

4. ALTERNATE NAMES (IF "NONE" ENTER "NONE")

LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
None			

5. CURRENT ADDRESS

STREET NUMBER & NAME: 2255 Winter Parkway, #98, Cuyahoga Falls, OH 44221

CITY	STATE	ZIP CODE	COUNTRY
Cuyahoga Falls,	Ohio	44221	USA

6. PHYSICAL DESCRIPTION

HEIGHT	WEIGHT	HAIR COLOR	COLOR OF EYES	IDENTIFYING MARKS
5'4"	130#	Black	Brown	None

7. SEX MALE [ ] FEMALE [x] FOR STATISTICS ONLY (Optional)

8. CITY IN OHIO WHERE YOU PLAN TO PRACTICE:

CITY	OR	COUNTY
Akron		Summit

PLANS OF PRACTICE: Residency Training

9. SPECIALTY BOARDS (USA, Canada and foreign countries)

NAME OF SPECIALTY BOARD	BOARD CERTIFIED YES	BOARD CERTIFIED NO	YEAR CERTIFIED	COUNTRY
N/A	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		

FOR OFFICE USE ONLY 34 ~~[illegible]~~ 35

1-8
37-35-97
5-16-91
185 [illegible]

9 MAY 13 AM 11:04
STATE MEDICAL BOARD

PAPERCLIP (DO NOT STAPLE) YOUR CHECK OR MONEY ORDER HERE

RESUME

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. If in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Webb

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
a. 7 / 89 (month / year)	University of South Alabama Medical Center Hospital/University/Other			
TO 2 / 91 (month / year)	2451 Fillingim St. Mobile, AL 36617 Street Address City/State Zip	PGY-1 and 2 OB/GYN	100	0
b. 3 / 91 (month / year)	Akron City Hospital Hospital/University/Other			
TO present (month / year)	525 East Market St. Akron, OH 44309 Street Address City/State Zip	PGY-2 OB/GYN	100	0
c. month / year	Hospital/University/Other			
TO month / year	Street Address City/State Zip			
d. month / year	Hospital/University/Other			
TO month / year	Street Address City/State Zip			
e. month / year	Hospital/University/Other			
TO month / year	Street Address City/State Zip			

91 MAY 13 AM 11:04

STATE MEDICAL BOARD

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
f. month year TO month year	Hospital/University/Other Street Address City/State Zip			
g. month year TO month year	Hospital/University/Other Street Address City/State Zip			
h. month year TO month year	Hospital/University/Other Street Address City/State Zip			
i. month year TO month year	Hospital/University/Other Street Address City/State Zip			
j. month year TO month year	Hospital/University/other Street Address City/State Zip			
k. month year TO month year	Hospital/University/Other Street Address City/State Zip			
l. month year TO month year	Hospital/University/Other Street Address City/State Zip			

ADDITIONAL INFORMATION

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO FURNISH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON AND DISPOSITION OF THE MATTER. ALL AFFIRMATIVE ANSWERS MUST BE THOROUGHLY EXPLAINED ON A SEPARATE SHEET OF PAPER.

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	[ ]	[X]
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges for other than reasons of failure to maintain records on a timely basis or failure to attend staff or section meetings?	[ ]	[X]
3.	Have you ever resigned, withdrawn, or terminated, or have you ever been requested to resign, withdraw, or otherwise terminate your position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	[ ]	[X]
4.	Have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from a medical school, clinical clerkship, externship, preceptorship, or postdoctoral training program?	[ ]	[X]
5.	Have you ever transferred from one postdoctoral training program to another?	[X]	[ ]
6.	Have you ever, for any reason, lost Specialty Board Certification in the U.S. or elsewhere?	[ ]	[X]
7.	Has any board, bureau, department, agency, or other body limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand against you?	[ ]	[X]
8.	Have you ever voluntarily surrendered any professional license, certificate, or registration issued to you by a board, bureau, department, agency, or other body?	[ ]	[X]
9.	Have you ever been requested to appear before any board, bureau, department, agency, or other body concerning allegations against you?	[ ]	[X]
10.	Have you ever entered into an agreement of any kind with respect to a professional license, whether oral or written, in lieu of formal disciplinary action, with any board, bureau, department, agency or other body?	[ ]	[X]
11.	Have you ever been notified of any charges or complaints filed against you with any board, bureau, deparment, agency, or other body with respect to a professional license?	[ ]	[X]
12.	Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or other drugs affecting the central nervous system, or any drugs which may cause physical or psychological dependence?	[ ]	[X]

13.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[X]
14.	Have you ever been treated but not hospitalized, for emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[X]
15.	Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, been requested to appear before or fined by the responsible agency?	[ ]	[X]
16.	Have you ever been convicted or been found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	[ ]	[X]
17.	Have you ever forfeited collateral, bail or bond for breach or violation of any law, police regulation, or ordinance other than for minor traffic violation, been summoned into court as a defendant, or had any lawsuit (other than malpractice suit) filed against you?	[ ]	[X]
18.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf or paid such a claim yourself?	[ ]	[X]
19.	Have you ever been denied, or relinquished, participation in any third party reimbursement program, whether governmental or private, or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	[ ]	[X]
20.	Have you ever been denied licensure, application for licensure, or privilege of taking examination, or withdrawn any application, in any state, territory, province, or country for any reasons?	[ ]	[X]

FORM 1

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, John R. Karlen M.D., a licensed and practicing physician in the state of
Name of Recommending Physician

Ohio affirm that Chandra Webb M.D., has been known
Name of Applicant

to me personally and professionally for 1 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Excellent
His/her command of the English language is: Excellent
I rate his/her ability to work well with peers and medical staff as: Excellent
His/her relationship with patients is: Excellent
Additional comments: _____

I hereby recommend him/her for full licensure to practice medicine/osteopathic medicine in Ohio.

John Karlen MD
Signature of Recommending Physician

John R. Karlen M.D.
Name of Recommending Physician
(Please print or type)

75 Arch Street Suite 402
Akron, Ohio 44304
Address of Recommending Physician
(Include City, State, Zip)

216-375-3174
Telephone Number
(Include Area Code)

(SEAL)

Ohio 37937
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 19th day of August, 1991.

Elizabeth Lynn Hoff (nee Hawkins)
Notary Public

March 30, 1994
Date Commission Expires

STAP [photo] RT PHOTO

Chandra G. Webb
Signature of Applicant

August 12, 1991
Date Photo Taken

STATE OF OHIO
THE STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17th FLOOR
COLUMBUS, OHIO 43215

91 AUG 21 AM 8:18

FORM 1 AMG

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, Thomas M. Miller, a licensed and practicing physician in the state of
Name of Recommending Physician
Alabama affirm that Chandra Y. Webb, has been known
Name of Applicant
to me personally and professionally for 1 1/4 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Above average
His/her command of the English language is: excellent
I rate his/her ability to work well with peers and medical staff as: excellent
His/her relationship with patients is: Above average
Additional comments: Caring

I hereby recommend him/her for full licensure to practice medicine/osteopathic medicine in Ohio.

Signature of Recommending Physician

THOMAS M. MILLER, M.D., M.P.H.
DIPLOMATE, A.B.O.G.

ALABAMA DEPARTMENT OF PUBLIC HEALTH
Assistant State Health Officer
Department of Public Health Area V
Consultant-Obstetrics & Gynecology
Bureau of Family Health Services
434 Monore Street
Montgomery, Alabama 36130-1701 Phone: (205) 242-5133

Thomas M. Miller
Name of Recommending Physician
(Please print or type)

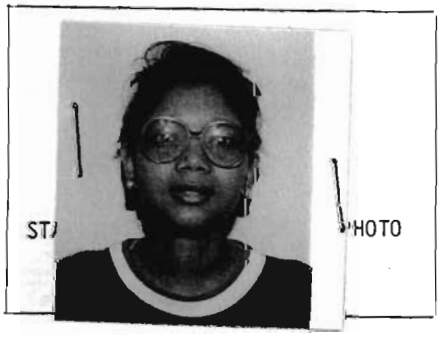
205-242-5133
Telephone Number
(Include Area Code)

Alabama 10408
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 22nd day of May, 19 91.

Notary Public

MY COMMISSION EXPIRES MARCH 7, 1993
Date Commission Expires



Chandra Y. Webb
Signature of Applicant

May 16, 1991
Date Photo Taken

Upon completion return to:

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

STATE MEDICAL BOARD OF OHIO
91 JUN -5 AM 10:32

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

MAIL TO HOSPITAL OR INSTITUTION OF POSTGRADUATE TRAINING IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice medicine in the State of Ohio. The State Medical Board of Ohio requires that my postgraduate training be certified. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

This certifies that Chandra Y. Webb (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[x] intern
[ ] resident in Obstetrics/Gynecology (Department)
[ ] clinical fellow

at The University of South Alabama Medical Center (Name of Hospital), 2451 Fillingim St Mobile, Alabama 36617 (Complete Address of Hospital)

from 7/1/89 (beginning month/day/year) to 6/30/90 (ending month/day/year). It is further certified that the above name

[x] was awarded a certificate on 6/30/90 (month/day/year)
[ ] was not

and that the training

[x] was accredited by ACGME/AOA.
[ ] was not

Signature of Medical Director or Program Director
(Original signatures only, name stamps will not be accepted)

(SEAL OF HOSPITAL)

Paula Autry, Assistant Administrator
Name (Please print or type)

5/14/91
Date

If the hospital has no seal, please indicate and have form notarized.

Upon completion return to:

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

FORM 4

MAY 13 1991

VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

TO BE COMPLETED BY APPLICANTS

Chandra Yvette Webb — Name in Full
15511 — License Number
September 1990 — Issue Date

2255 Winter Parkway, #98 Cuyahoga Falls, OH 44221 — Complete Address (Include zip code)
October 6, 1962 — Date of Birth

Morehouse School of Medicine — Medical School Graduation

I hereby authorize the licensing agency of the state or province of Alabama to furnish the information below to the State Medical Board of Ohio.

Chandra Y. Webb — Signature of Applicant
May 8, 1991 — Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province: Alabama
Name of Licensee: Chandra Yvette Webb, M.D.

License Number: 15511
Date Issued: 9/14/90
Is license current? Yes
If not, please explain: _____

What is the basis of the license?

[ ] 1. Flex examination in _____
[ ] 2. Written examination prepared by this state or province
[X] 3. National Boards
[ ] 4. LMCC
[ ] 5. Endorsement from _____ (State/Province)
[ ] 6. Other (Please Specify) _____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES _____ NO X CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? YES _____ NO X CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES _____ NO X CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

Leon C. Hamrick, M.D. Key director

(BOARD SEAL)

Signed: LEON C. HAMRICK, M.D.
Title: Chairman
Date: May 15, 1991

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

Please return to:
STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

AFFIDAVIT AND RELEASE

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below must be completed by ALL applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being returned to you.

ss STATE OF Ohio

COUNTY OF Summit

I, Chandra Y. Webb hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true, tha I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my applicatio are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and the Routes to Licensure and I have answered all questions in compliance with these instruction and understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report wil be privileged.

I further understand that failure to complete this application as requested by the Board withi six months can be considered as abandonment of any request for licensure and that any fee I submitted is not refundable or transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent dat and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives, and any person furnishing information, any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize th State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization, or similar institution; or to any professional association.

I further understand that a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained therein or to be furnished, which if false, can subject me to permanent denial of said certificate.

Chandra Y. Webb
Signature of Applicant

Subscribed and sworn to before me this 9th day of May 1991.

Elizabeth Lynn Hoff (nee Hawkins)
Notary Public Signature

(NOTARY SEAL)

March 30 1994
Date Commission Expires

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO _____

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

Ray 2. Bunger
Entrance Examiner

Secretary

Date Issued

FOR BOARD USE ONLY

NAME: [illegible]

CERTIFICATE #: 62556 DATE ISSUED 10-10-91

FILED [illegible], 19 [illegible]

FEE _____

DETERMINATION:

BOARD ACTION: 9/91 Bd

BASIS OF LICENSURE:

37-35

PRELIMINARY EDUCATION FORM

AW

My name IN FULL is Webb, (LAST) Chandra (FIRST) Yvette (MIDDLE)

High School or Equivalent:

SCHOOL NAME	CITY	STATE	COUNTRY
Friendly Sr. High	Oxon Hill,	MD	USA

FROM: MO/YR	TO: MO/YR	DEGREE
9 / 77	6 / 80	Diploma

Undergraduate College or Equivalent:

SCHOOL NAME	CITY	STATE	COUNTRY
Agnes Scott College	Decatur,	GA	USA

FROM: MO/YR	TO: MO/YR	DEGREE
9 / 80	6 / 84	B.A. Chemistry

SCHOOL NAME	CITY	STATE	COUNTRY

FROM: MO/YR	TO: MO/YR	DEGREE
/	/	

Medical School of Graduation:

SCHOOL NAME	CITY	STATE	COUNTRY
Morehouse Sch of Med	Atlanta,	GA	USA

FROM: MO/YR	TO: MO/YR	DEGREE
7 / 85	5 / 89	MD

RDB

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: 7219

DATE ISSUED: 7-2-91

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

Ray L. Bumgarner
Entrance Examiner

Henry D. Cramblett M.D.
Secretary

AKRON CITY HOSPITAL

A Voluntary Nonprofit Hospital

Albert F. Gilbert, Ph.D.
President

Thomas R. Kelly, M.D.
Director of Medical Education
Professor of Surgery
Associate Dean for Clinical Sciences
Northeastern Ohio Universities
College of Medicine

March 4, 1991

April R. Davidson
Asst. to the Chief of Licensure
The Ohio State Medical Board
77 South High Street - 17th Floor
Columbus, Ohio

Dear Ms. Davidson:

Please send me an application for permanent licensure for the State of Ohio.

Mail to:

Chandra Webb, M.D.
2255 Winter Parkway #98
Cuyahoga Falls, Ohio 44221

S.F.
SENT
3/8/91

STATE MEDICAL BOARD OF OHIO
91 MAR -8 AM 8:58

Thank you.

Sincerely,

Chandra Y. Webb

Chandra Webb, M.D.

WEBB, Chandra

Morehouse School of Medicine

in consideration of the satisfactory completion
of all requirements prescribed by the faculty
hereby confers upon

Chandra Yvette Webb

the degree of

Doctor of Medicine

together with all the rights, privileges and responsibilities appertaining thereto.
In testimony whereof, the corporate seal and the signatures as authorized by the
Board of Trustees are hereunto affixed.

Given at Atlanta, Georgia

May 20, 1989

Clinton Warner
Chairman of the Board of Trustees

Secretary of the Board of Trustees

MOREHOUSE SCHOOL OF MEDICINE
KNOWLEDGE • WISDOM • EXCELLENCE • SERVICE

James R. Goodman
President

Dean

I HEREBY CERTIFY THIS TO BE A TRUE, UNALTERED PHOTOCOPY OF THE ORIGINAL DIPLOMA ISSUES TO CHANDRA YVETTE WEBB BY THE MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GEORGIA, DATED MAY 20, 1989.
Certified this 21st day of June, 1991.

Elizabeth Lynn Hoff (nee Hawkins) - Notary Public STATE MEDICAL BOARD
My Commission Expires: 3-30-94

91 JUN 24 AM 9:54

Chandra Y. Webb
Redacted

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

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Chandra Y. Webb, M.D.

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

Attest L. THOMPSON BOWLES, M.D., PH.D.
Chairman of the Board

SEAL ROBERT L. VOLLE, PH.D.
President of the Board

Philadelphia, Pa.
07/01/90

Certificate # 379613

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from MOREHOUSE SCH OF MEDICINE in MAY 1989 and whose birth date is 10/06/1962. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/87		
Anatomy	520	82
Physiology	380	73
Biochemistry	515	81
Pathology	425	76
Microbiology	390	75
Pharmacology	430	76
Behavioral Sciences	540	83
TOTAL TEST (Minimum Passing Score 380/75)	450	77
PART II passed 09/88		
Medicine	380	76
Surgery	360	75
Obstetrics and Gynecology	525	83
Public Health and Preventive Medicine	300	72
Pediatrics	405	77
Psychiatry	475	81
TOTAL TEST (Minimum Passing Score 290/75)	385	77
PART III passed 03/90		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	310	75
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		76

91 MAY 29 AM 8:01

STATE MEDICAL BOARD OF OHIO

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

Melanie Valente
Secretary for Certification

SEAL

05/22/91
Date

Item 5

I began my internship/residency at the University of South Alabama Medical Center in Mobile, Alabama in July 1989. I successfully completed my internship and continued into my second year of residency until February 1991. I transferred to Akron City Hospital March 1991 desiring more teaching, supervision and a chance to improve my surgical skills.

Chandra Y. Webb

Chandra Y. Webb, MD

Redacted

Akron City

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

DATE June 11, 1991

Dear Doctor:

Dr. Chandra Y. Webb, MD who is/was PGY-2-OB/GYN - 3-91 to present is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. This form must be completed and returned to our office within two (2) weeks to ensure processing of the doctor's application. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

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

(2) What is/was your supervisory capacity? Director of Medical Education

(3) At what hospital? Akron City Hospital

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

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

(6) Does this doctor work well with peers and medical staff? Yes

(7) Does he/she relate well to patients? Yes

(8) How is his/her command of the English language? (if applicable) NA

(9) Would you recommend this doctor for licensure? Yes

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

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

April R. Woody
April Woody
Licensure Assistant

Signature of Doctor, please type or print name legibly beneath

Ace Hodgin, M.D.

Director of Medical Education
Position

Telephone No. (216) 375-3107 (Include Area Code)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Chandra Y. Webb 6/22/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2556	$160.00	07/01/92

CHANDRA Y WEBB,M.D.
1651 AKRON PENINSULA RD
AKRON OH 44313

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

NOT ON FILE

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 39 CODE2 CODE3

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 0935062556 :00000160000:

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

Street
Street
City State Zip Code
County

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

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

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

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

SOCIAL SECURITY NUMBER
(Optional for purposes of Identification)

0883 00173 062992 01261 3
TAX BATCH P. DATE SEQ# MD#
AMOUNT BATCH# 06/30/92
ACCOUNT # 935062556

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Chandra Y Gravely 4/15/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2556	$250.00	05/01/94

CHANDRA Y GRAVELY,M.D.
11105 ZARING CT
CINCINNATI OH 45241

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

✓ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 cODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 0935062556 :00000250004:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
1845 READING RD STE #09
Street
Street
CINCINNATI OH 45237
City State Zip Code
HAMILTON
County

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

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

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

YES NO ✓ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

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

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

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

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

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

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Chandra Y Gravely
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2556	$250.00	05/01/96

CHANDRA Y GRAVELY,M.D.
11105 ZARING CT
CINCINNATI OH 45241

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 0935062556 :00000250000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
4725 16 GIAZARIN RD
Street
STE 362
Street
CINCINNATI OH 45236
City State Zip Code
HAMILTON
County

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

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

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

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES ☐ NO ☑

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

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

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

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

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

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Chandra Y Gravely 3/1/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2556-G	$307.00	05/01/98

CHANDRA Y GRAVELY,M.D.
11105 ZARING CT
CINCINNATI OH 45241

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935062556 "0000030700"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
4360 Cooper Rd
Street
Street
Cincinnati OH 45242
City State Zip Code
Hamilton
County

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

YES NO
☐ ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.
☐ ☑ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?
☐ ☑ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.
☐ ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?
☐ ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?
☐ ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?
☐ ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?
☐ ☑ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Chandra Y Gravely 7/21/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2556-G	$305.00	10/01/2000

CHANDRA Y GRAVELY,M.D.
11105 ZARING CT
CINCINNATI OH 45241

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

☐ **SPECIALTY CODE(S) CORRECT AS LISTED**

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.
11105 ZARING CT
STREET
STREET
CINCINNATI OH 45241
CITY STATE ZIP CODE
HAMILTON
COUNTY

:969696962: 0935062556" "0000030500"

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
4366 CLOPPER RD
Street
STE 1103
Street
CINCINNATI OH 45342
City State Zip Code
HAMILTON
County

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

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

YES ☐ NO ☒ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question if** you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☒ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☐ NO ☒ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?

YES ☐ NO ☒ 5.) Have you surrendered, or consented to limitation of a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☐ NO ☒ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

REQUIRED: SOCIAL SECURITY NUMBER Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2000 - 2002 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Chandra Gravely 7/16/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-2556-G	$305.00	10/01/02	01/01/03

CHANDRA Y GRAVELY,M.D.
11825 QUARTERHORSE CT
CINCINNATI OH 45249

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

11825 QUARTERHORSE CT
STREET
STREET
CINCINNATI OH 45249
CITY STATE ZIP CODE
HAMILTON
COUNTY

0935062556 30500

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

1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony? NO ☒ YES ☐

2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices. NO ☒ YES ☐

3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio? NO ☒ YES ☐

4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you? NO ☒ YES ☐

5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board. NO ☒ YES ☐

6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?** NO ☒ YES ☐

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

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

4360 COOPER ROAD #103
Street
Street
CINCINNATI OH 45242
City State Zip Code
HAMILTON
County

REQUIRED: Redacted
SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X Chandra McGravely 7/13/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 062556	305.00	10/1/2004	1/1/2005

Dr. CHANDRA Y GRAVELY
11825 QUARTERHORSE CT
CINCINNATI OH 45249

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG

[X] **SPECIALTY CODE(S) CORRECT AS LISTED**

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL

STREET: 11825 QUARTERHORSE CT
STREET:
CITY: CINCINNATI STATE: OH ZIP CODE: 45249
COUNTY: HAMILTON

SELECT ONE ADDRESS FOR MAILINGS FROM THE BOARD.
[X] RESIDENCE [ ] PRINICIPAL PRACTICE ADDRESS

0003654727 30500 35ZZ 062556

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR LICENSURE / RENEWAL IN OHIO :

YES [ ] NO [X] 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a felony or misdemeanor?

YES [ ] NO [X] 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.

YES [ ] NO [X] 3.) Have any malpractice awards or settlements been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES [ ] NO [X] 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?

YES [ ] NO [X] 5.) Have you surrendered, or consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES [ ] NO [X] 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

08302004 711700
1 0075037
1 SE 000030500

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL
[ ] Check this Box if you have NO principal Practice address.

Street: 10700 MONTGOMERY RD
Street: STE 311
City: CINCINNATI State: OH Zip Code: 45242
County: HAMILTON

Redacted

Date Posted: 8/30/2006 2:32:04 PM

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

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

Address Information

BUSINESS ADDRESS

10700 Montgomery Road
Suite 311
Cincinnati, OH 45242
Hamilton County
United States of America
513-891-0211

License Information

License Number 35.062556
License Name CHANDRA GRAVELY
Email Address

Fees

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

Specialty Codes

1. Please select one specialty from the field below
. . . . . OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
. . . . . *{not Answered}*
3. Please select one specialty from the field below, if applicable.
. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . YES

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . Theresa C Bauer, CNM

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

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

Date Posted: 10/9/2008 2:39:28 PM

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

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

License Information

License Number	35.062556
License Name	CHANDRA GRAVELY
Email Address	tina@crescentwomens.com

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

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. . . . . THERESA BAUER CNM

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Date Posted: 9/27/2010 12:33:16 PM

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