APP SENT
5/11/90

STATE MEDICAL BOARD
90 MAY 10 PM 3:06

STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

PLEASE TYPE OR PRINT CLEARLY

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

NAME: KRESS (LAST (Surname)) Timothy (FIRST) S. (MIDDLE) SUFFIX (Jr., II)

ADDRESS: 40 Creekwood Dr. #12 (STREET & NUMBER) Wilder (CITY) KY (STATE) 41071 (ZIP) USA (COUNTRY)

TELEPHONE: BUSINESS: (513) 569-6249 (AREA CODE & NUMBER) HOME: (606) 491-8689 (AREA CODE & NUMBER)

BIRTH DATE: 11/10/64 (MO/DAY/YR) BIRTH PLACE: Lousville (CITY) KY (STATE) USA (COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: U. of Cincinnati (SCHOOL NAME) 231 Bethesda Ave. (STREET ADDRESS) Cincinnati (CITY) OH (STATE) USA (COUNTRY)

9/1/85 (FROM: MO/DAY/YR) 6/10/89 (TO: MO/DAY/YR) MD. (DEGREE RECEIVED) 6/10/89 (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 ____ NUMBER ____________ DATE ISSUED / /

FIFTH PATHWAY

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

ADDRESS: STREET & NUMBER CITY STATE ZIP DATE: / / (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: Bethesda Hospital (NAME) 619 Oak St. (STREET ADDRESS) Cincinnati (CITY) OH (STATE)
POSITION: Resident - I DEPARTMENT: OB/GYN DATE: 7/89 (FROM: MO/YR) current (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

HOSPITAL: NAME STREET ADDRESS CITY STATE

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: NONE. 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: NONE ISSUE DATE: / / LICENSE #: ______ CURRENT: YES__ NO__

BASIS OF LICENSURE: ______

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: ______ DATE TAKEN: ______ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

STATE: ______ DATE TAKEN: ______ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

STATE: ______ DATE TAKEN: ______ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? PENDING ✓ YES ____ NO ____ DATE /

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

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

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

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

A GRADUATE OF A MEXICAN MEDICAL SCHOOL? YES ___ NO ✓ 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 ____

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

IF YES, GIVE FULL ADDRESS AT THAT TIME:

886 New England	Centerville	OH	45429
STREET ADDRESS	CITY	STATE	ZIP

CERTIFICATION

I, Timothy S. Kress, 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.

Timothy S. Kress — SIGNATURE

5-5-90 — DATE

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

Abna 7-12-90 BETHESDA 7-20-90

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)
Kress	Timothy	Scott	

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

LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
Kress	Timothy	S.	

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

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

5. CURRENT ADDRESS

STREET NUMBER & NAME: 40 Creekwood Dr. #12

CITY	STATE	ZIP CODE	COUNTRY
Wilder	Kentucky	41071	USA

6. PHYSICAL DESCRIPTION

HEIGHT	WEIGHT	HAIR COLOR	COLOR OF EYES	IDENTIFYING MARKS
6' 1"	275 lb.	Brown	Blue	

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

8. CITY IN OHIO WHERE YOU PLAN TO PRACTICE: Cincinnati CITY OR COUNTY

PLANS OF PRACTICE: OB/GYN (Currently OB/GYN Resident)

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

NAME OF SPECIALTY BOARD	BOARD CERTIFIED YES	BOARD CERTIFIED NO	YEAR CERTIFIED	COUNTRY
	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		

FOR OFFICE USE ONLY 34 35

1-7
55 A5-U
7-12-90
185.00 pd 60

90 JUL 11 STATE ...

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.

KRESS

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. July '89 (month year)	Bethesda Hospital (Hospital/University/Other)	OB/GYN Dept. Resident	100%	
TO (month year)	619 Oak St., Cincinnati, OH 45206 (Street Address City/State Zip)			
b. (month year)	Hospital/University/Other			
TO (month year)	Street Address City/State Zip			
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			

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			

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, Harold E. Johnstone, M.D. (Name of Recommending Physician), a licensed and practicing physician in the state of Ohio affirm that Timothy S. Kress (Name of Applicant), has been known to me personally and professionally for 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: 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: well motivated, caring physician

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

[signature]
Signature of Recommending Physician

Harold E. Johnstone, M.D.
Name of Recommending Physician
(Please print or type)

629 Oak St., Suite #105 Cinti, O. 45206
Address of Recommending Physician
(Include City, State, Zip)

(513) 569-6249
Telephone Number
(Include Area Code)

[signature]
State of Licensure and License Number
of Recommending Physician

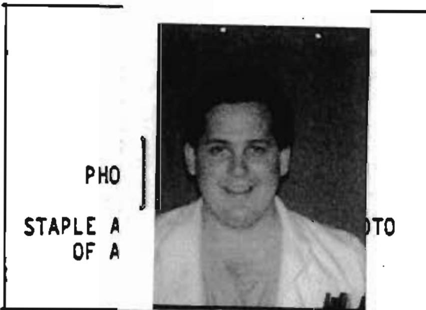
(SEAL)

Subscribed and sworn to this 6th day of July, 19 90.

Janet H. Cooke
Notary Public

October 9 1994
Date Commission Expires

JANET H. COOKE
Notary Public, State of Ohio
My Commission Expires Oct. 9, 1994



PHO
STAPLE A
OF A
TO

Upon completion return to:

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

Timothy S. Kress
Signature of Applicant

7-3-90
Date Photo Taken

AMS

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, Karl Ziesmann, M.D., a licensed and practicing physician in the state of
Name of Recommending Physician
Ohio affirm that Timothy S. Kress, has been known
Name of Applicant
to me personally and professionally for 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: Good
His/her command of the English language is: N.A.
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.

[signature]
Signature of Recommending Physician

Karl Ziesmann, M.D.
Name of Recommending Physician
(Please print or type)

629 Oak St., Suite #301 Cinti, O. 45206
Address of Recommending Physician
(Include City, State, Zip)

(513) 569-6249
Telephone Number
(Include Area Code)

(SEAL)

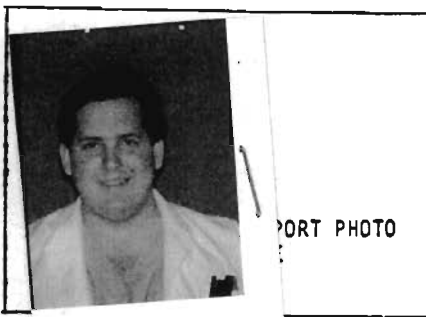
Ohio 20566
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 9th day of July, 1990.

Janet H. Cooke
Notary Public

October 9, 1994
Date Commission Expires

JANET H. COOKE
Notary Public, State of Ohio
My Commission Expires Oct. 9, 1994


PASSPORT PHOTO

Upon completion return to:

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

Timothy S. Kress
Signature of Applicant

7-3-90
Date Photo Taken

***THIS FORM SHALL NOT BE COMPLETED MORE THAN 30 DAYS PRIOR TO COMPLETION OF ATLEAST 12 MONTHS OF TRAINING

AD

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 Timothy S. Kress (Name of Applicant) has rendered satisfactory and continuous service as a(n)
[✓] intern
[ ] resident in OB/GYN (Department)
[ ] clinical fellow

at Bethesda Hospital (Name of Hospital), 629 Oak St., Suite #301 Cinti, O. 45206 (Complete Address of Hospital)

from July 1, 1989 beginning (month/day/year) to June 30, 1990 ending (month/day/year). It is further certified that the above name
[✓] was awarded a certificate on 6 30 90 (month/day/year)
[ ] was not

and that the training
[✓] was accredited by ACGME/AOA.
[ ] was not

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

(SEAL OF HOSPITAL)

Harold E. Johnstone, M.D.
Name (Please print or type)

7/3/90
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

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]

AFFIDA ND 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 Hamilton

I, Timothy Scott Kress 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, that 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 applicatior 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 instructions 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 data 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 the 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.

Timothy S Kress
Signature of Applicant

Subscribed and sworn to before me this 18th day of June 1990.

Janet H. Cooke
Notary Public Signature

(NOTARY SEAL)

Oct. 9 1994
Date Commission Expires

JANET H. COOKE
Notary Public, State of Ohio
My Commission Expires Oct. 9, 1994

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 L. Bumgarner
Entrance Examiner

Henry G. Cramblett M.D.
Secretary

____
Date Issued

JANET H. COOK
Notary Public, State of Ohio
My Commission Expires Oct. 9, 1994

FOR BOARD USE ONLY

NAME: Kress, Timothy S.

CERTIFICATE #: 60555 DATE ISSUED 9-7-90

FILED May 11, 19 90

FEE ______________________

DETERMINATION: 8/90 PV

BOARD ACTION:

BASIS OF LICENSURE:

Bethesda Hosp.

STATE OF OHIO
THE STATE MEDICAL BOARD
17th Floor
77 South High Street
Columbus, Ohio 43266-0315

DATE July 20, 1990

Dear Doctor:

Dr. KRESS, Timothy Scott who is/was OB/GYN Resident 7/89-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 papers for licensure. 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? 4 years

(2) What was/is your supervisory capacity? Director of Residency Training

(3) At what hospital? Bethesda - Cincinnati

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

(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? very well

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

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

(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,

Dawn Cales
Dawn Cales
Licensure Assistant

Harold E Johnstone MD
Signature of Doctor, please type or print name legibly beneath

Harold E. Johnstone, M.D.

Director, OB/GYN Residency Training Program
Position

DATE: 7/26/90

Telephone No. (513) 569-6249 (Include Area Code)

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

Timothy S. Kress, 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 # 371895

STATE MEDICAL BOARD
90 JUL 20 PM 4:19

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 U CINCINNATI COL MEDICINE in JUNE 1989 and whose birth date is 11/10/1964. 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 09/87		
Anatomy	550	84
Physiology	605	87
Biochemistry	470	79
Pathology	365	73
Microbiology	590	86
Pharmacology	515	81
Behavioral Sciences	495	80
TOTAL TEST (Minimum Passing Score 380/75)	520	81
PART II passed 04/89		
Medicine	480	81
Surgery	495	81
Obstetrics and Gynecology	655	88
Public Health and Preventive Medicine	540	83
Pediatrics	465	80
Psychiatry	415	78
TOTAL TEST (Minimum Passing Score 290/75)	505	82
PART III passed 05/90		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	455	80

GENERAL AVERAGE (Parts, I, II, and III Scale Score) 81

*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

07/16/90
Date

7/12

The Board of Trustees of the

University of Cincinnati

on the recommendation of the Faculty of the

College of Medicine

of the University, does hereby confer upon

Timothy Scott Kress

the degree of

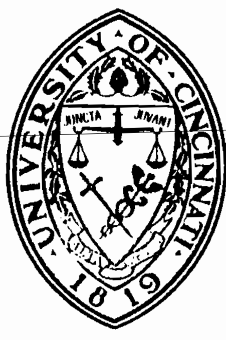
Doctor of Medicine

with all the rights and privileges appertaining thereto. Given at Cincinnati, Ohio this eleventh day of June, nineteen hundred and eighty-nine.

90 JUL 11 AM 11:53

Stanley M. Chesley
Chairman of the Board of Trustees

Marjorie B. Parham
Secretary of the Board of Trustees



Joseph A. Steger
President of the University

John J. Hutton
Dean of the College

1-1 22-25-4
7/12/90

PRELIMINARY EDUCATION FORM

STATE MEDICAL BOARD
90 MAY 10 PM 3:0

My name In FULL is Kress (LAST) Timothy (FIRST) Scott (MIDDLE)

High School or Equivalent: Centerville HS (SCHOOL NAME) Centerville (CITY) OH (STATE) USA (COUNTRY)

9/78 (FROM: MO/YR) 5/82 (TO: MO/YR) High School Diploma (DEGREE)

Undergraduate College or Equivalent: Univ. Dayton (SCHOOL NAME) Dayton (CITY) OH (STATE) USA (COUNTRY)

8/82 (FROM: MO/YR) 7/85 (TO: MO/YR) B. Science Chemical Engineering (DEGREE)

SCHOOL NAME CITY STATE COUNTRY

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

Medical School of Graduation: U. Cincinnati (SCHOOL NAME) Cincinnati (CITY) OH (STATE) USA (COUNTRY)

9/85 (FROM: MO/YR) 6/89 (TO: MO/YR) MD (DEGREE)

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 77176

DATE ISSUED: 8/15/90

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 Q. Bumgarner
Entrance Examiner

Henry G. Cramblett M.D.
Secretary

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 Timothy S Kress 8-1-92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0555	$160.00	07/01/92

TIMOTHY SCOTT KRESS,M.D.
40 CREEKWOOD DR #12
WILDER KY 41071

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. 39 CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

969696962 0935060555 0000016000

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 PLED GUILTY OR NO CONTEST TO :

YES	NO	
☐	X	A.) A felony or misdemeanor.
☐	X	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	
☐	X	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.
☐	X	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?
☐	X	3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?
☐	X	4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

Redacted
(Optional for purposes of Identification)

783 00350 081892 00700 150 00 081292 3506060555
TAX BATCH # DATE SEQ# AMOUNT BATCHDATE ACCOUNT #

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 [signature] 11 18 94

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35060555	~~$250.00~~ 275.00	05/01/94

TIMOTHY SCOTT KRESS, M.D.
FAMILY HEALTH
5735 MEEKER RD
GREENVILLE OH 45331

2.7
46-4. 86
11-25-94
275 - fee

⑆969696962⑆ 2 7/01

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

0935060555⑈ ⑈0000025000⑈

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

Street

Street

City State Zip Code

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.) 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? YES ☐ NO ☒

SOCIAL SECURITY NUMBER: Redacted
(Optional for purposes of identification)

DETACH HERE AND RETAIN THIS PORTION FOR YOUR RECORDS

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 Timothy S Kress 5-6-96

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0555	$250.00	05/01/96

TIMOTHY SCOTT KRESS,M.D.
FAMILY HEALTH
5735 MEEKER RD
GREENVILLE OH 45331

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⑆ 0935060555⑈ ⑈0000025000⑈

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

Street

Street

City State Zip Code

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 YES ☐ NO ☒

SOCIAL SECURITY NUMBER (Optional for purposes of identification) Redacted

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 Timothy S Kress 6/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0555-K	$275.00	05/01/98

TIMOTHY SCOTT KRESS,M.D.
FAMILY HEALTH
5735 MEEKER RD
GREENVILLE OH 45331

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⑆ 0935060555⑈ ⑈0000027500⑈

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

Street
Street
City State Zip Code
County

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

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

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

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

YES [ ] NO [X] 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)
Redacted

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 Timothy S Kress 9-28-00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35060555-K	$305.00	07/01/00

TIMOTHY SCOTT KRESS,M.D.
4473 OLD ENGLISH CIRCLE
BELLBROOK OH 45305

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.
4473 Old English Circle
STREET
STREET
Bellbrook OH 45305
CITY STATE ZIP CODE
Greene
COUNTY

STATE MEDICAL BOARD
OCT - 2 2000

3E

32-10-64 # 4303 # $305 10-3-00

OK for WC RLL 2/1/01

⑆96969696 2⑆ 0935060555⑈ ⑈0000030500⑈

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
NONE
Street
Street
City State Zip Code
County

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

YES	NO	
X		1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?
X		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?
X		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.
	X	4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?
	X	5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?
X		6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances?
X		7.) Had any clinical privileges or other authority to practice suspended,restricted or revoked for reasons other than failure to maintain records or 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 Timothy S Kress 6-25-02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-0555-K	$305.00	07/01/02	10/01/02

TIMOTHY SCOTT KRESS,M.D.
2898 RIVER END COURT
SPRING VALLEY OH 45370

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

[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

2898 RIVER END COURT
STREET

STREET

SPRING VALLEY OH 45370
CITY STATE ZIP CODE

GREENE
COUNTY

0935060555 30500

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

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 misdemeanor or felony?

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 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 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?**

07022002 711700
2 0049 025
060555
1 SE 000030500

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

[ ] Check this Box if you have NO principal Practice address.

290 NORTHLAND BLVD
Street

Street

SPRINGDALE OH 45246
City State Zip Code

HAMILTON
County

REQUIRED
Redacted
SOCIAL SECURITY NUMBER

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 [signature] 6-21-04

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 060555	305.00	7/1/2004	10/1/2004

Dr. TIMOTHY SCOTT KRESS
2898 RIVER END COURT
SPRING VALLEY OH 45370

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: 2898 RIVER END CT

STREET:

CITY: SPRING VALLEY STATE: OH ZIP CODE: 45370

COUNTY: GREENE

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

0003656491 30500 35ZZ 060555

AT ANY TIME SINCE SIGNING YOUR L[illegible]
APPLICATION FOR LICENSURE / RENEW[illegible]
IN OHIO :

YES [ ] NO [X] 1.) Have you been fou[illegible] guilty of, or pled guilty or contest to, or receiv[illegible] treatment or intervention lieu of conviction of, a felo[illegible] or misdemeanor?

YES [ ] NO [X] 2.) Have you been addicted or dependent upon alcohol any chemical substance; been treated for, or be[illegible] diagnosed as suffering fro[illegible] drug or alcohol depender[illegible] or abuse? ***You may answ[illegible] "NO" to this question*** if y[illegible] have successfully complet[illegible] treatment at, or are currentl[illegible] enrolled in, a program approv[illegible] by this Board and have adhered to all statutory requiremer[illegible] during and subsequent to treatment. You must answer "YE[illegible] if you have ever relapsed. Any questions concerning progra[illegible] approval or concerning this question can be directed to t[illegible] board offices.

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

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

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

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

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

[ ] Check this Box if you have NO principal Practice address.

Street: 290 NORTHLAND BLVD

Street:

City: CINCINNATI State: OH Zip Code: 45246

County: HAMILTON

REQUIRED: SOCIAL SECURITY NUMBER Redacted

06242004 777700
0055 028
I SE 000030500

Date Posted: 7/1/2006 1:14:48 AM

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

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

License Information

License Number	35.060555
License Name	TIMOTHY KRESS
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.**

.... Yvonne Clark, CNP; Latanya Davis, CNP; Anne Erickson, CNM; Anne Etges, CNP; Nancy Hogan, CNP; Sarah Kramer, CNP; Deb Magnotta, CNP; Diane Roach, CNM; Michelle Schlarmann, CNP; Tammy Schwing, CNP; Deb Seeger, CNP; Leslie Stidd, CNP; Beverly Wells, CNP; Crystal Wilmhoff, CNP; Sarah Wilson, CNP

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: 9/3/2008 9:38:16 AM

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

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

License Information

License Number	35.060555
License Name	TIMOTHY KRESS
Email Address	kressmdjd@woh.rr.com

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, revoked or placed on probation 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.**

.... Catherine A. Mauser, CNM: Molly Dickinson, CNM; Denise Robinson, CNP; Whitney Vangen, CNP; Pamela Kraft, CNP; Leslie Stidd, CNP; Tamara Schwing, CNP; Sarah Kramer, CNP; Sarah Wilson, CNP; Marcelle Bobst, CNP; Crystal Wilmhoff, CNP; Michelle Schlarman, CNP; Beverly Wells, CNP

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: 7/1/2010 1:49:34 AM

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

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License Information

License Number	35.060555
License Name	TIMOTHY KRESS

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?
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in Ohio **other than this board,** filed any charges, allegations or complaints against you?

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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.**

.... Janine Baer, CNP; Molly Dickinson CNM; Sarah Kramer CNP; Beverly Wells CNP; Julie Treadway CNP; Crystal Wilmhoff CNP; Tracy Dillingham CNM; Lauren Theuerling CNP; Michelle Schlarmann CNP; Sarah Wilson CNP

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Date Posted: 4/21/2012 12:35:21 AM

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

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

Address Information

BUSINESS ADDRESS	2314 Auburn Avenue CINCINNATI, OH 45219 Hamilton County United States of America 937-604-0488 kressmdjd@woh.rr.com

License Information

License Number	35.060555
License Name	TIMOTHY KRESS

Fees

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

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

   .... YES

Specialty Codes

1. Please select one specialty from the field below

   .... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.

   .... GYNECOLOGY
3. Please select one specialty from the field below, if applicable.

   .... LEGAL MEDICINE

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?

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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.**

   .... Jessica Crider, CNP; Sarah Wilson, CNP; Crystal Wilmhoff, CNP; Jessica Moon, CNM; Tracy Dillingham, CNP; Allison Heist, CNP; Michelle Schlarman, CNP; Angela Robinson, CNP; Bev Wells, CNP; Aurora Cardenas-Ball, CNP; Melinda Chimento, CNP

Ohio Employment

1. Do you practice in Ohio?

.... YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

.... 15-19

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

.... 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

.... 10-14

4. "Education" - preceptor, mentor, etc.

.... 10-14

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

.... 1-4

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

.... 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

.... 10-14

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

.... 0

3. Enter the number of hours per week spent in "Emergency Room".

.... 0

4. Enter the number of hours per week spent in "Urgent Care".

.... 0

5. Enter the number of hours per week spent in "Other".

.... 5-9

Workforce Counties

1. Enter the first zip code:

.... 45219

2. Enter the first county:

.... Hamilton

3. Enter the second zip code:

.... 45402

4. Enter the second county:

.... Montgomery

5. Enter the third zip code:

.... 45011

6. Enter the third county:

.... Butler

7. Do you have more than one practice location?

.... YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

.... 2314 Auburn Ave., Cincinnati, OH 45219; 224 North Wilkinson, Dayton, OH 45402; 11 Ludlow, Hamilton, OH 45011; 1061 North Bechtle, Springfield, OH 45504; 834 Ohio Pike, Withamsville, OH 45245; 290 Northland Blvd., Springdale, OH 45246; 2016 Ferguson, Cincinnati, OH 45246

Practice Arrangement (size)

1. Solo practitioner

.... NO

2. Single-specialty Group

.... 2-5

3. Multi-specialty Group

.... N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

.... NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

.... YES

Languages

1. Select a language from the drop down list.

.... Spanish

2. Select a language from the drop down list.

.... *{not Answered}*

3. Select a language from the drop down list.

.... *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

.... YES

ABMS Specialty

1. Choose specialty from the dropdown list.

.... Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

.... *{not Answered}*

3. Choose specialty from the dropdown list.

.... *{not Answered}*

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