FOR BOARD USE ONLY:	APP, AMA, FORM 2, TSE MAILED: 2/2/99

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

REQUEST FOR APPLICATION FORMS
MEDICAL OR OSTEOPATHIC

PLEASE TYPE OR PRINT CLEARLY

Check one: ☑ I am ☐ I am not applying for Step 3 of the USMLE in May 1999 (Fill in year) December _____ (Fill in year)

SYTED-1 PM 1:02 STATE MEDICAL BOARD

The following information must be completed by ALL applicants, whether or not you are applying to take the USMLE for Ohio.

PERSONAL INFORMATION

	Last (Surname)	First	Middle	Suffix (Jr., II)
NAME:	GINDE	SAVITA	YESHAWANT	

	Number & Street			
ADDRESS:	3800 JOYCE ANN DRIVE			
	City	State	Zip Code	Country
	YOUNGSTOWN	OH	44511	USA

		Area Code & Number		Area Code & Number
TELEPHONE:	BUSINESS:	(216) 421 4433	HOME:	(330) 793 2171

	MO/DAY/YR		City	State	Country
BIRTH DATE:	02/16/70	BIRTH PLACE:	TOLEDO	OHIO	USA

MEDICAL OR OSTEOPATHIC EDUCATION

	School Name		
MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION	AMERICAN UNIVERSITY OF THE CARIBBEAN		
	Street Address		
	MEDICAL EDUCATION INFORMATION OFFICE, 901 PONCE DE LEON BLVD, SUITE 801		
	City	State	Country
	CORAL GABLES	FLORIDA	USA

		MO/YR		MO/YR
DATES ATTENDED:	FROM:	08/93	TO:	06/97

DEGREE RECEIVED:	MS, MD	DATE RECEIVED:	MO/DAY/YR 06/06/97

OVER ⇨

OTHER MEDICAL OR OSTEOPATHIC SCHOOLS ATTENDED (IF NONE, ENTER "NONE"):

School Name		
N/A		
Street Address		
City	State	Country

DATES ATTENDED: FROM: MO/YR / TO: MO/YR /

Reason degree not received at this school:

School Name		
Street Address		
City	State	Country

DATES ATTENDED: FROM: MO/YR / TO: MO/YR /

Reason degree not received at this school:

FIFTH PATHWAY PROGRAM

FIFTH PATHWAY PROGRAM (IF NONE, ENTER "NONE"):

Hospital or Institution	
NONE	
Name of Medical School	
City	State

DATES ATTENDED: FROM: MO/YR / TO: MO/YR /

QUALIFYING EXAM TAKEN: DATE TAKEN: MO/YR /

CONTINUED ⇨

MD/DO REQUEST FOR APPLICATION FORMS
PAGE 3

STATE MEDICAL BOARD

99 FEB -1 PM

GRADUATE MEDICAL EDUCATION

List **ALL** graduate medical education (internship, residency or clinical fellowship), undertaken in the U.S. or Canada. If additional space is needed, attach an extra sheet. **(If none, enter "NONE")**

month/year TO month/year	Hospital, University or Other: / Complete Street Address: / Number & Street / City / State/Country / Zip Code	Position & Department	Level of Training *(check one only)*
7 98 TO 6 99	PHS MT SINAI MEDICAL CENTER ONE MT SINAI DRIVE CLEVELAND OH/USA 44106	TRANSITIONAL RESIDENT; DEPT OF MEDICINE	☑ 1st year ☐ 2nd year ☐ 3rd year or above
TO	N/A		☐ 1st year ☐ 2nd year ☐ 3rd year or above
TO			☐ 1st year ☐ 2nd year ☐ 3rd year or above
TO			☐ 1st year ☐ 2nd year ☐ 3rd year or above

OVER ⇨

WRITTEN EXAMINATIONS TAKEN

List each and every written exam (FLEX, National Boards, USMLE, State Board, LMCC) taken, whether in Ohio or any other state, territory or province. Use one section for each exam portion taken. If additional space is needed, attach an extra sheet.

STATE/PROVINCE	DATE TAKEN	TYPE OF EXAM	SECTIONS TAKEN	FINAL RESULTS
OHIO	(MO/YR) 9/95	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☑ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☑ 1 ☐ 2 ☐ 3 ☐ Partial ☑ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☑ PASS ☐ FAIL
OHIO	(MO/YR) 6/95	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☑ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☑ 1 ☐ 2 ☐ 3 ☐ Partial ☑ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☐ PASS ☑ FAIL
OHIO	(MO/YR) 3/97	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☑ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☐ 1 ☑ 2 ☐ 3 ☐ Partial ☑ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☑ PASS ☐ FAIL
	(MO/YR)	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☐ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☐ 1 ☐ 2 ☐ 3 ☐ Partial ☐ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR)	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☐ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☐ 1 ☐ 2 ☐ 3 ☐ Partial ☐ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR)	(✓ ONE ONLY) ☐ FLEX (pre-1985) ☐ FLEX (1985-1994) ☐ National Boards (MD or DO) ☐ USMLE ☐ State Board ☐ LMCC	(✓ ONE ONLY) ☐ Partial ☐ Full Component: ☐ I ☐ II Part: ☐ 1 ☐ 2 ☐ 3 Step: ☐ 1 ☐ 2 ☐ 3 ☐ Partial ☐ Full ☐ Partial ☐ Full	(✓ ONE ONLY) ☐ PASS ☐ FAIL

CONTINUED ⇨

. 1

STATE MEDICAL BOARD

99 FEB -1 PM 3:56

LICENSES IN THE UNITED STATES & CANADA

List ALL states/provinces, **whether the license is current or not**, in which you are or have been licensed (except temporary, educational permits) to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number, date of issuance and the basis of licensure. If additional space is needed, attach an extra sheet. **(If none, enter "NONE")**

STATE/PROVINCE	ISSUE DATE	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
NONE	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date: ____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date: ____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date: ____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date: ____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date: ____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date: ____
	(MO/YR)		(✓ ONE ONLY) ❑ National Boards ❑ FLEX ❑ USMLE ❑ LMCC ❑ State Board exam ❑ Other:____	(✓ ONE ONLY) ❑ YES ❑ NO Expiration Date: ____

OVER ⇨

ADDITIONAL ELIGIBILITY INFORMATION FOR GRADUATES OF NON ACCREDITED LCME/AOA SCHOOLS

ANSWER ALL QUESTIONS	YES	NO
Do you have a valid ECFMG Certificate? Number: 0533589 8 Date Issued: 8 / 97 (MO/YR)	☑	☐
Have you held a current and unrestricted license in the U.S. for **at least five years or more**? *(Refer to the TSE section in the Eligibility Packet for more information)*	☐	☑
Have you been actively practicing medicine and surgery or osteopathic medicine and surgery (approved training included) in the U.S. for **at least five years or more**? *(Refer to the TSE section in the Eligibility Packet for more information)*	☐	☑
Have you applied for or taken the Test of Spoken English (TSE*) of the Educational Service (ETS)? Date Taken: ___/___ (MO/YR) Score: _____	☐	☑

***THE TOEFL, ECFMG EXAM, ETC. ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (TSE)**

FEDERATION CREDENTIALS VERIFICATION SERVICE

	YES	NO
Have you completed and forwarded the FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) application packet to FCVS?	☐	☑

If yes, date forwarded: _____

CERTIFICATION

I hereby certify that I am the person referred to in the foregoing Request for Application forms and that the statements herein are strictly true in every respect.

_____ 01/05/99
Signature of Applicant Date

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

CONTINUED ⇨

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FOR BOARD USE ONLY
BK: 5 ☐ 34 ☐ 35 PG: 14 LN: 53
DATE 2.18.99 FEE: $35.00 PMT: # 1029

APPLICATION FOR EXAMINATION - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: Redacted

2. Full Name (Use no initials):

LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
GINDE	SAVITA	YESHAWANT	

3. Maiden Name or other names used If none, enter "NONE"):

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

4. Current Address:

STREET & NUMBER			
30 SEVERANCE CIRCLE, APT #720			
CITY	**STATE**	**ZIP CODE**	**COUNTRY**
CLEVELAND HEIGHTS	OH	44118	USA

5. Physical Description:

HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	IDENTIFYING MARKS
5'8"	125Lbs.	DK. BRN.	DK. BRN	MOLE RT FORE HEAD

6. Sex: ☐ MALE ☑ FEMALE For statistics only (optional)

7. Specialty Boards (U.S.A., Canada and foreign countries):

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
NONE	☐	☐		
	☐	☐		
	☐	☐		

CONTINUED ⇨

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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 "seeking employment", as well as your permanent address.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did "locum tenens", you must list all hospitals where you worked and include complete dates and addresses. **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, please attach separate sheets.

	month/year	Hospital, University or Other:	Complete Street Address:	Position & Department	% Clinical	% Admin.
A	07 97 TO 12 97	KRESGE EYE INST. WAYNE STATE UNIVERSITY	DEPT. of OPHTHALMOLOGY 4717 St. ANTOINE BLVD Number & Street DETROIT MI 48201-1423 City State/Country Zip Code	Research Asst; Dept. of Ophthalmology	100	0
B	01 98 TO 06 98	AMERICAN FOUNDATION FOR THE BLIND	11 PENN PLAZA, SUITE 300 Number & Street NEW YORK NY 10001 City State/Country Zip Code	Research Intern, Low Vision Rehabilitation Policy Research Dept	100	0
C	07 98 TO present	PHS Mt. SINAI MEDICAL CENTER	1 Mt SINAI DRIVE Number & Street CLEVELAND OH 44106 City State/Country Zip Code	Transitional Resident, Dept of Medicine	100	0
D	TO		Number & Street City State/Country Zip Code			

OVER ⇨

E	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City State/Country Zip Code	Position & Department	% Clinical % Admin.
F	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City State/Country Zip Code	Position & Department	% Clinical % Admin.
G	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City State/Country Zip Code	Position & Department	% Clinical % Admin.
H	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City State/Country Zip Code	Position & Department	% Clinical % Admin.

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

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.

(Please place a ☑ in the YES or NO box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
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 or resign privileges at 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 reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or 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 graduate medical education?	☐	☑
5.	Have you ever transferred from one graduate medical education to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑

OVER ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

		YES	NO
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by, or have you ever been notified of, any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Are you now or have you ever been, addicted to or excessively used alcohol, drugs, or other substances which may cause physical or psychological dependence, or impairment of the ability to practice?	☐	☑
14.	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 an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
15.	Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

		YES	NO
16.	Have you ever been denied, or surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑
17.	Have you ever been convicted or found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	☐	☑
18.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☑
19.	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? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
20.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage cancelled, limited, or restricted in any way?	☐	☑
21.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
22.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

State Medical Board of Ohio

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Applicant check one: I am applying to sit for Step 3 of the USMLE in ☑ May or ☐ December 1999 (fill in year)

MEDICINE OR OSTEOPATHIC MEDICINE

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 physician must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physician 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 A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, AMARJEET S NAGPAUL MD, a licensed and practicing physician in the state of
(recommending physician)

OHIO, affirm that SAVITA Y GINDE
(state of residence) (applicant)

has been known to me personally for 18 years and that he/she is of good moral character.

Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application:

*I rate his/her medical knowledge and technique as: EXCELLENT

*His/her relationship with patients is: EXCELLENT

*I rate his/her ability to work well with peers and medical staff as: EXCELLENT

*His/her command of the English language is: EXCELLENT

*Additional comments: _____

I hereby recommend him/her to take the examination in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

A S Nagpaul

Signature of Recommending Physician
(name stamps not acceptable)

AMARJEET S. NAGPAUL M D

Name of Recommending Physician
(please type or print clearly)

(330) 726-5500

Telephone Number
(include area code)

755 BOARDMAN-CANFIELD RD, BLDG F SUITE #1

Address of Recommending Physician
(include city, state and zip code)

Ohio 35-04-0484-N

State of Licensure & License Number of Recommending Physician
(please type or print clearly)

Subscribed and sworn to before me this 9 day of Feb, 1999.

Notary Public Signature

JOSEPH A. SACCHINI JR.
NOTARY PUBLIC, STATE OF OHIO
MY COMMISSION EXPIRES SEPT. 30, 2001

Date Commission Expires

Signature of Applicant

Date Photo Taken: 02 / 99
Mo/Yr

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

Revised 10/21/96

State Medical Board of Ohio

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Applicant check one: I am applying to sit for Step 3 of the USMLE in ☑ May or ☐ December 1999 (fill in year)

MEDICINE OR OSTEOPATHIC MEDICINE

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 physician must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physician 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 A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Roop K. Kollipara (recommending physician), a licensed and practicing physician in the state of OHIO (state of residence), affirm that SAVITA Y. GINDE (applicant) has been known to me personally for 25 years and that he/she is of good moral character.

Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application:

*I rate his/her medical knowledge and technique as: Very good

*His/her relationship with patients is: Professional and trusting

*I rate his/her ability to work well with peers and medical staff as: excellent

*His/her command of the English language is: Excellent

*Additional comments: She is an asset to the medical community

I hereby recommend him/her to take the examination in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

R. Kollipara
Signature of Recommending Physician
(name stamps not acceptable)

ROOP K. KOLLIPARA
Name of Recommending Physician
(please type or print clearly)

(330) 747-6759
Telephone Number
(include area code)

540 PARMALEE AVE #410 YOUNGSTOWN OH 44510
Address of Recommending Physician
(include city, state and zip code)

OH 041819
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

Subscribed and sworn to before me this 9 day of Feb, 1999.

Notary Public Signature

(NOTARY SEAL)

JOSEPH A. SACCHINI JR.
NOTARY PUBLIC, STATE OF OHIO
MY COMMISSION EXPIRES SEPT. 30, 2001

Date Commission Expires

Signature of Applicant

Date Photo Taken: 02/99
Mo/Yr

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

Revised 10/21/96

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

April 6, 1999

Savita Yeshawant Ginde MD
30 Severance Cir., #720
Cleveland Hts., OH 44118

Dear Doctor:

Your application for the 5/11-12/99 USMLE Step 3 has been received. However, a review of your application indicates the following:

1. Your core credentials packet from the Federation Credentials Verification Service (FCVS) has not been received. If you have submitted the application to FCVS you will be notified by them of the status. Do not call FCVS or the Ohio Board simply to inquire about the status of your application. Please note that the Ohio Board requires verification of not less than one year of postgraduate training. ***Therefore, since you will not be completing your 1st year of training until 6/30/99, the Federation will not forward your FCVS packet until verification has been received from your training program.*** Once your profile is completed, FCVS will send you an acknowledgment letter that your packet has been forwarded to the Ohio Board.

2. The Physician Profile from the American Medical Association (AMA) has not been received. Profiles are sent directly to Ohio Board within 15 business days after receipt by the AMA. If you have forwarded the profile to the AMA and it has been longer than 30 business days then contact the AMA at (312) 464-5199 to inquire about the status of your profile.

Do not contact the Board to inquire about the status of your application or to inform the Board that you have requested the information. Time spent answering telephone inquiries is time lost from processing applications.

Unless you are otherwise notified, we will continue processing your application for the examination.

Notification of specific dates, times, and location will be sent at least 30 days prior to the first day of the exam. Please be advised that your examination site is determined by the Federation of State Medical Boards and not the Ohio Board.

BE SURE TO NOTIFY THE BOARD, IN WRITING, OF ANY CHANGE IN ADDRESS.

Sincerely,

Penny E. Grubb

Penny E. Grubb
Chief, Licensure

Direct Dial: (614) 466-9234
FAX: (614) 644-1464
E-Mail Address: Penny.Grubb@med.state.oh.us

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 considered as incomplete.

ss STATE OF: OHIO
COUNTY OF: MAHONING

I, SAVITA GINDE, hereby certify under oath that I am the person named in this application to take the examination 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 application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

I further state that by filing this application to take the examination in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to sit for the examination. 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 will be privileged.

I further understand that my application to take the examination in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to admission to the examination being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request to take the examination and that any fee I submitted is not refundable nor 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 examination, 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, of 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 admittance to the examination in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said examination.

Signature of Applicant

Subscribed and sworn to before me this 9 day of Feb 199 9.

(NOTARY SEAL)

Signature of Notary Public

JOSEPH A. SACCHINI JR.
NOTARY PUBLIC, STATE OF OHIO
MY COMMISSION EXPIRES SEPT. 30, 2001

Date Commission Expires

Revised 10/21/96

FOR BOARD USE ONLY

NAME: S. Y. Ginde, MD

CERTIFICATE NO.: _____

DATE ISSUED: _____, 199____

APPLICATION FOR EXAMINATION
MEDICINE OR OSTEOPATHIC MEDICINE

FILED: 2-20, 1999

DETERMINATION:

BOARD ACTION:

Grade

STATE ... DEC 26 2000

RESUME OF ACTIVITIES - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order beginning with medical school graduation, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", as well as your permanent address.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **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, please attach separate sheets. You must account for ALL time.

From Month/Year	Hospital, University or Other / Complete Street Address / City / State/Country / Zip Code	Position & Department	% Clinical / % Admin.
07/97 to 01/98	Kresge Eye Institute, Wayne State University Detroit / MI/USA / 48201	Ophthalmology Research Extern	80 / 20
02/98 to 06/98	American Foundation for the Blind New York / NY/USA / 10001	Low Vision Rehabilitation Policy, Research Extern.	75 / 25
07/98 to 06/99	Mt. Sinai Medical Center Cleveland / OH/USA / 44106	Intern, Transitional Program, Dept of Internal Medicine	100 / 0
07/99 to present	NH-Dartmouth FP Residency, Concord Hospital Concord / NH/USA / 03301	Resident, Dept of Family Medicine	98 / 2
/ to /			

OVER ⇨

RESUME OF ACTIVITIES - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE 2

From Month/Year / To Month/Year /	Hospital, University or Other Complete Street Address City State/Country Zip Code	Position & Department	% Clinical % Admin.
From Month/Year / To Month/Year /	Hospital, University or Other Complete Street Address City State/Country Zip Code	Position & Department	% Clinical % Admin.
From Month/Year / To Month/Year /	Hospital, University or Other Complete Street Address City State/Country Zip Code	Position & Department	% Clinical % Admin.
From Month/Year / To Month/Year /	Hospital, University or Other Complete Street Address City State/Country Zip Code	Position & Department	% Clinical % Admin.
From Month/Year / To Month/Year /	Hospital, University or Other Complete Street Address City State/Country Zip Code	Position & Department	% Clinical % Admin.
From Month/Year / To Month/Year /	Hospital, University or Other Complete Street Address City State/Country Zip Code	Position & Department	% Clinical % Admin.

STATE [illegible]

DEC 26 2000

State Medical Board of Ohio

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FOR BOARD USE ONLY			
☐ 34	☐ 35		
BK: 22	PG: 110	LN: 24	
DATE: 1-9-01	FEE: $335.00	PMT: 221	

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

IDENTIFICATION

Social Security Number: Redacted

Your social security number is required to facilitate reporting to the Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under Ohio's child support enforcement law (§2301.373.O.R.C.) It may also be used for investigation/enforcement purposes.

	Last (Surname)	First	Middle	Suffix (Jr., II)
Full Name (Use no initials)	GINDE	SAVITA	YESHAWANT	
Name (As you prefer it inscribed on your Ohio license)	GINDE	SAVITA	YESHAWANT	
Maiden Name or Other Names Used (If none, enter "NONE"):	NONE			

Current Home **Address** IMPORTANT Nofity the Board office immediately in writing of any change in address	Number and Street: 3800 JOYCE ANN DRIVE		Apt.	
	City: YOUNGSTOWN	State: OH	Zip Code: 44511	Country: USA

Telephone Number	Business: area code & number ( ) N/A	Home: area code & number (330) 793 2171

Birth Date	month/day/year: 02/16/70	Birth Place	City: TOLEDO	State: OH	Country: USA

Physical Description	Height: 5'8"	Weight: 130lb.	Hair Color: dk. brn	Eye Color: dk. brn	Identifying marks: mole right forehead

Gender: ☐ Male ☑ Female For statistics only (optional)

Are you currently in an accredited training program in Ohio? ☐ Yes ☑ No

If yes, please identify name of training program and location:

OVER ⇨

WRITTEN EXAMINATION

Indicate which licensing examination you have passed:

- ☐ National Boards (MD or DO)
- ☑ USMLE Steps 1, 2, 3
- ☐ FLEX (Pre-1985)
- ☐ State Board exam
- ☐ FLEX Components 1 & 2
- ☐ LMCC
- ☐ Other, explain:_____

LICENSES IN THE UNITED STATES AND CANADA

List ALL states/provinces in which you hold or have held a license to practice medicine and surgery or osteopathic medicine and surgery, including a temporary license, training certificate, educational permit, or other license or certificate, ***whether the license is current or not***. If additional space is needed, attach an extra sheet. **(If none, enter "N/A"). A Form 2, Verification of License, must be sent to each state listed.**

STATE/PROVINCE	ISSUE DATE (MO/YR)	LICENSE NO.	LICENSE CURRENT YES	LICENSE CURRENT NO	EXPIRE(S)
New Hampshire	06/99	RT 788	☑	☐	6/28/02
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

SPECIALTY BOARDS

NAME OF SPECIALTY BOARD (If none, enter "N/A")	YEAR CERTIFIED	COUNTRY
N/A		

CONTINUED ⇨

DEC 26 2000

FEDERATION CREDENTIALS VERIFICATION SERVICE

Ohio requires verification of your core credentials directly through the Federation Credentials Verification Service (FCVS).

Have you completed and forwarded the FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) application packet to FCVS? ☑ YES ☐ NO

If yes, date forwarded: November 23,00

ECFMG CERTIFICATE
(International Medical School Graduates only)

ECFMG Number	0-533-589-8	Date Issued	8/22/97	Expiration Date	Indefinitely

TEST OF SPOKEN ENGLISH
(International Medical Graduates only)

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 40 (230 if taken prior to 7/95) on the Educational Testing Services Test of Spoken English (TSE), regardless of citizenship or country of birth, unless you meet one of the following:

Have you completed two years of undergraduate college work in the United States?	☑ YES ☐ NO
Have you held a current license (includes temporary license, training certificate or educational permits) in the United States for **at least five years** **AND** have you been actively practicing medicine or osteopathic medicine and surgery in the United States (includes approved graduate medical education training) for **at least five years**?	☐ YES ☑ NO
Have you completed a Fifth Pathway program?	☐ YES ☑ NO

If you answered **NO** to all of the above questions you must take the TSE. Refer to the application instructions for contacting the Educational Testing Service.

THE TOEFL, ECFMG EXAM, ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH.

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

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. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
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 or resign privileges at 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 reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or 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, residency, or graduate medical education program?	☐	☑
5.	Have you ever transferred from one graduate medical education program to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑

OVER ⇨

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☑
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☑
17.	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? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

CONTINUED ⇨

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	☐	☑
22.	a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
	b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☑

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

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

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

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

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	☐	☑
	a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program? If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☑
	b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☑

OVER ⇨

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☑
	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☑

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.	☐	☐

State Medical Board of Ohio

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MEDICINE OR OSTEOPATHIC MEDICINE
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 physician must have known 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 ensure that certain information is included.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, STEPHEN ELLIOTT, MD., a licensed and practicing physician in the state of NEW HAMPSHIRE.
(recommending physician, print name) (state of residence)

affirm that SAVITA Y. GINDE has been known to me personally for 1 1/2 years and that he/she is of
(applicant, print name)

good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

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

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street 250 PLEASANT ST.			Telephone Number (include area code)	225-2711 EXT 4492
	City Concord	State NH.	Zip Code 03301		
Signature of Recommending Physician (name stamps not acceptable)				State of Licensure & License Number	NH - 06608

Signature of Applicant

Date Photo Taken: 6/00
Mo/Yr

Subscribed and sworn to before me this 21st day of November, 2000.

Kathleen A. Cesere
Notary Public Signature

KATHLEEN A. CESERE, Notary Public
My Commission Expires November 20, 2001
Date Commission Expires

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS.

State Medical Board of Ohio

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MEDICINE OR OSTEOPATHIC MEDICINE
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 physician must have known 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 ensure that certain information is included.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Gail Sawyer (recommending physician, print name), a licensed and practicing physician in the state of NEW HAMPSHIRE (state of residence)

affirm that SAVITA Y. GINDE (applicant, print name) has been known to me personally for 2 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: Excellent
- His/her relationship with patients is: Excellent
- I rate his/her ability to work well with peers and medical staff as: Excellent
- His/her command of the English language is: Excellent
- Additional comments: No reservations for this recommendation

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 250 Pleasant St City: Concord State: NH Zip Code: 03301	Telephone Number (include area code)	(603) 228-7200
Signature of Recommending Physician (name stamps not acceptable): Gail J Sawyer		State of Licensure & License Number	NH 9687

Signature of Applicant: Savita Y. Ginde

Date Photo Taken: 6/00 (Mo/Yr)

Subscribed and sworn to before me this 21st day of November, 2000.

Kathleen A. Cesere
Notary Public Signature

KATHLEEN A. CESERE, Notary Public
My Commission Expires November 20, 2001
Date Commission Expires

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS.

NEW HAMPSHIRE BOARD OF MEDICINE

This is to certify that the records of the New Hampshire Board indicate the following information:

LICENSEE: SAVITA Y GINDE MD

LICENSE NUMBER: RT-788

ISSUE DATE: 06/28/1999

EXPIRATION DATE: 06/28/2002

DISCIPLINARY ACTION: NONE

DATE: 12/28/2000

To expedite the certification of licensure process, the above is the standard format for all professionals regulated by this Board.

Sharon Canney
Secretary

(SEAL)

2 INDUSTRIAL PARK DRIVE SUITE 8 CONCORD, NH 03301-8520 TDD Access: Relay NH 1-800-735-2964 TEL (603) 271-1203 FAX (603) 271-6702

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

MEDICINE OR OSTEOPATHIC MEDICINE
FORM 2 - 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.

TO BE COMPLETED BY APPLICANT

Name	Last: GINDE	First: SAVITA	Middle: YESHAWANT	Suffix (Jr., II):
Current Address	Number & Street: 120 Fisherville Road Unit 136		License Number: RT 788	
	City: Concord	State: NH	Zip: 03303	Date of Birth: Month/Day/Year: Feb / 16 / 1970
Medical/Osteopathic School of Graduation	AMERICAN UNIVERSITY OF THE CARIBBEAN			

I hereby authorize the licensing agency of the State of New Hampshire to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant	[signature]	Date	12/19/00

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State				
Name of Licensee	Last	First	Middle	Suffix (Jr., II)
License Number		Issue Date month/day/year: / /	License current? If not, please explain	☐ Yes ☐ No

	Yes	No	Cannot answer under current state law
Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?	☐	☐	☐
Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?	☐	☐	☐
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?	☐	☐	☐

If yes, please attach complete details.

AFFIX BOARD SEAL NOT VALID WITHOUT SEAL

Signature

Title

Date

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS.

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Savita Yeshawant Ginde**
SSN:	Redacted
DOB:	**02/16/1970**
Recipient:	**State Medical Board of Ohio**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

The Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. The Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Savita Yeshawant Ginde**	
Other Name Used:	**N/A**	
Gender:	**Female**	
Date of Birth:	**02/16/1970**	
Place of Birth:	**Toledo, OH USA**	
SSN:	Redacted	
Current Address:	**120 Fisherville Road # 136** **Concord, NH 03303-1012**	
Permanent Address:	**3800 Joyce Ann Drive** **Youngstown, OH 44511**	
Telephone Numbers:	Bus:	**603-228-7200 x 4790**
	Fax:	**N/A**
	Home:	**603-224-7645**
	Other:	**603-564-8275**
Physical Description:	Height:	**5' 08"**
	Weight:	**130 lbs**
	Eye Color:	**Dark Brown**
	Hair Color:	**Dark Brown**
Physical Marks:	Description:	**Dark Brown Nevus**
	Location:	**Right Forehead**

Premedical Education (Reported by physician. Not verified by FCVS)**:**

Institution:	**University of Pennsylvania, Philadelphia, PA 19104-6291**
Dates of Attendance:	**08/1988 - 05/1992**
Degree Awarded:	**Bachelor of Arts**
Institution:	**University of Cincinnati, Cincinnati, OH 45221-0060**
Dates of Attendance:	**09/1992 - 06/1993**
Degree Awarded:	**N/A**

Medical Education:

Current, valid ECFMG	**Yes**
ECFMG Number:	**05335898**
Date Issued:	**08/22/1997**
Medical School:	**School of Medicine, American University of the Caribbean** **901 Ponce de Leon/Suite 201** **Coral Gables, FL 33134**
Dates of Attendance:	**08/30/1993 - 06/07/1997**
Graduation Date:	**06/07/1997**
Degree Awarded:	**Doctor of Medicine**

Unusual Circumstance:	**Leave** **See Form**

Post Graduate Medical Education:

Institution:	**Mt Sinai Medical Center of Cleveland** **Department of Medical Education** **One Mt Sinai Drive** **Cleveland, OH 44106-4198**
Post Graduate Year:	**1**
Program Type:	**Transitional**
Department:	**Internal Medicine**
Dates of Attendance:	**07/01/1998 - 06/30/1999**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**
Institution:	**New Hampshire Dartmouth Family Practice Residency-Concord** **Department of Family Practice** **250 Pleasant Street** **Concord, NH 03301**
Post Graduate Year:	**2**
Program Type:	**Residency**
Department:	**Family Practice**
Dates of Attendance:	**06/28/1999 - 06/30/2000**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**3**
Program Type:	**Residency**
Department:	**Family Practice**
Dates of Attendance:	**07/01/2000 - 06/30/2001**
Completion:	**To Be Completed On 06/30/2001**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Omission / Discrepancy Report

Physician Identification:

Name:	Savita Yeshawant Ginde
DOB:	02/16/1970
SSN:	Redacted
Packet ID:	9437
Request ID:	5912698

REPORT OF OMISSIONS

There are no omissions in this physician's FCVS file.

REPORT OF DISCREPANCIES

Discrepancy 1:

Section of Profile: **Medical Education**

Discrepancy: The applicant reports no unusual circumstances during attendance at American U Of Caribbean (documentation provided). The institution reports Leave.

Follow-Up: A written explanation from the institution is included on the Medical Education form.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile: **Continuity of Education**

Issue: There is a gap of approximately 1 year between graduation from medical school at American U Of Caribbean (06/07/1997) and entrance into the postgraduate training program at Mt Sinai Medical Center of Cleveland (begins 07/01/1998).

Follow-Up: FCVS does not verify or report any foreign postgraduate training programs in which the applicant may have participated.

End of report for Savita Yeshawant Ginde

Packet Id: 9437 Request Id: 5912698 Report Created By: TJL

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name:	**Ginde, Savita Yeshawant**
Date of Birth:	**02/16/1970**
Medical School:	**654010 - American U Of Caribbean**
Year of Graduation:	**1997**
Social Security Number:	Redacted
ECFMG Number:	**0-533-589-8**

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

FEB 1 2 2001

James R. Winn, M.D.

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

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make are true, that I am the person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies I furnish with my application are strictly true.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize every person, hospital, clinic, government agency (local, state, federal or foreign), institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, or true and correct copies of documents or records.

I hereby release, discharge and hold harmless the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, records or documents of any and all liability. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

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

GINDE
Applicant's Printed Last Name

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

11/21/2000
Date of Signature (must correspond to date of notarization)

State of New Hampshire, County of Merrimack,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 21st day of November, 2000.

Notary Public signature: Kathleen A. Cesere

My commission expires: KATHLEEN A. CESERE, Notary Public
My Commission Expires November 20, 2001

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

PACKET ID:

Follow Up Requested

OHIO DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF LIVE BIRTH

Registrar's No. 1605

Birth No. 134 - 70 033566

1st No. 48
Primary Reg. Dist. No. 4801

CHILD—NAME	First: Savita	Middle: Yeshawant	Last: Ginde	DATE OF BIRTH (Month, Day, Year) 2a. February 16, 1970	HOUR 2b. 8:24 A. M.
SEX: Female	THIS BIRTH —Single, twin, triplet, etc. (Specify) 4a. Single	IF NOT SINGLE BIRTH —Born first, second, third, etc. (Specify) 4b.		COUNTY OF BIRTH 3a. Lucas	
CITY, VILLAGE, OR LOCATION OF BIRTH: Toledo	INSIDE CITY LIMITS (Specify yes or no) 5c. Yes	HOSPITAL—NAME (If not in hospital, give street and number) 5d. Riverside Hospital			
MOTHER—MAIDEN NAME	First: Padma	Middle: Prabha	Last: Divekar	AGE (At time of this birth) 6b. 30	STATE OF BIRTH (If not in U.S.A., name country) 6c. India
RESIDENCE—STATE: Ohio	COUNTY 7b. Lucas	CITY, VILLAGE, OR LOCATION 7c. Toledo		INSIDE CITY LIMITS (Specify yes or no) 7d. Yes	STREET AND NUMBER 7e. 510 Stickney Ave.
FATHER—NAME	First: Yeshawant	Middle: Vasudevrao	Last: Ginde	AGE (At time of this birth) 8b. 33	STATE OF BIRTH (If not in U.S.A., name country) 8c. India
INFORMANT'S NAME OR SIGNATURE: Yeshawant Vasudevrao Ginde					RELATION TO CHILD 9b. Father
I certify that the above named child was born alive at the place and time and on the date stated above. SIGNATURE: Samuel Zuker			DATE SIGNED 10b. 2/25/70		ATTENDANT—M.D., D.O., midwife, other (specify) 10c. M.D.
CERTIFIER—NAME (Type or Print): Samuel Zuker, M.D.			MAILING ADDRESS (Street or R.F.D. No., City or Village, State, Zip) 10e. 424 W. Woodruff, Toledo, Ohio 43624		
REGISTRAR'S SIGNATURE					DATE RECEIVED BY LOCAL REGISTRAR MAR 10 1970

The Secretary of State
of the United States of America
hereby requests all whom it may concern to permit the citizen/
national of the United States named herein to pass
without delay or hindrance and in case of need to
give all lawful aid and protection.

Le Secrétaire d'Etat
des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer
le citoyen ou ressortissant des Etats-Unis titulaire du présent passeport,
sans délai ni difficulté et, en cas de besoin, de lui accorder
toute aide et protection légitimes.

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE

NOT VALID UNTIL SIGNED

UNITED STATES OF AMERICA

PASSPORT
PASSEPORT

USA

Type/Catégorie: P
Code of issuing State / code du pays émetteur: USA
PASSPORT NO./NO. DU PASSEPORT: 087456357

Surname / Nom: GINDE

Given names / Prénoms: SAVITA YESHAWANT

Nationality / Nationalité: UNITED STATES OF AMERICA

Date of birth / Date de naissance: 16 FEB/FEV 70

Sex / Sexe: F

Place of birth / Lieu de naissance: OHIO, U.S.A.

Date of issue / Date de délivrance: 01 MAR/MAR 99

Date of expiration / Date d'expiration: 28 FEB/FEV 09

Authority / Autorité: PASSPORT AGENCY
NEW ORLEANS

Amendments/ Modifications
SEE PAGE
24

P<USAGINDE<<SAVITA<YESHAWANT<<<<<<<<<<<<<<<<

087456357 3USA7002162F0902285<<<<<<<<<<<<<<<8

By the signature and seal affixed hereto, the Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Name: J. L. P. Date: 4-12-99

Title: Credentials Verification Analyst

Section III

Medical Education

RECEIVED JUN 0 1 1999

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: School of Medicine, American University of the Caribbean

Complete Address: Post Office Box 400
Street Address
Plymouth Montserrat
Street Address
British West Indies
City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

Enrollment and Participation: Our records indicate that Ginde, Savita Yeshawant
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 144 weeks of continuous on-campus education on the following dates (mm/dd/yy):

From	To
08 / 30 / 93	05 / 01 / 94
05 / 02 / 94	01 / 01 / 95
01 / 02 / 95	04 / 30 / 95
08 / 28 / 95	04 / 26 / 96
04 / 27 / 96	01 / 05 / 97
01 06 97	06 07 97

This individual (check one):

____ was awarded the degree of Doctor of Medicine on 06 / 07 / 97 (mm/dd/yy)

____ was NOT awarded a degree (please attach an explanation)

RECEIVED
JUN 2 8 1999
By

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response. **"Yes" responses to any of these questions requires a written explanation.**

Questions	Response
Did this individual ever take a leave of absence or break from their medical education? Study leave	(Yes) No
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or under investigation?	Yes (No)
Were any negative reports regarding this individual ever filed by instructors?	Yes (No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes (No)

Premedical Education: Does your school have a premedical education requirement? (Yes) No

If yes, include where your records indicate the individual completed his/her premedical education and the basic science courses taken (attach additional pages if necessary):

Premedical Institution(s): University of Pennsylvania
University of Cincinnati

Check Courses Taken:
- X Physics
- ✓ Biology/Zoology
- ✓ Organic Chemistry
- ✓ Inorganic Chemistry

Certification: By my signature, I, Yife Tien (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized).

Signature: Yife Tien

Title: Director

Date of Signature: 5/26/99

Telephone: (305) 446 0600

SEAL VERIFIL

Applicant: Print your complete last name: GINDE

14. Medical Education Outside the U.S or Canada

Complete this page only if you have attended a medical school located outside the U.S. or Canada.

List all of the medical schools you attended. You may photocopy this page to report more than one (1) institution, if necessary.

DOCUMENTATION:

You must include a legible photocopy of your medical school diploma.

AMERICAN UNIVERSITY OF THE CARIBBEAN

Complete Name of Medical School (Do not abbreviate)

Complete Name of Affiliated University or College (Do not abbreviate)

MEDICAL EDUCATION INFORMATION

Address Line 1

OFFICE 901 PONCE DE LEON BLVD

Address Line 2

CORAL GABLES

City

Province

33134036

Zip/Postal Code

USA

Country

Duration of medical degree program: From: 08 (Month) 1993 (Year) To: 06 (Month) 1997 (Year)

Duration of additional clinical training (if applicable): From: (Month) 19 (Year) To: (Month) 19 (Year)
(i.e., training required before degree is conferred)

Degree (as it appears on your diploma): ☐ MBBS ☐ MBBCh ☑ Other: MD
☐ Did Not Graduate

Exact Date Degree was Conferred: 06 (Month) 07 (Day) 1997 (Year)

Unusual Circumstances (circle Yes or No):

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8½ x 11 sheet of paper. Your response may not exceed 100 words per question.

Did you take a leave(s) of absence or break(s) from your medical education?	YES	(NO)
Were you ever placed on probation?	YES	(NO)
Were you ever disciplined or placed under investigation?	YES	(NO)
Were any negative reports ever filed against you?	YES	(NO)
Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems, or for any other reason?	YES	(NO)

Please explain any "Yes" response from above:

15. Fifth Pathway

Complete this section only if you participated in a Fifth Pathway Program.

DOCUMENTATION:

You must include a legible photocopy of your Fifth Pathway Certificate.

N/A

Complete Name of Medical School that Awarded Fifth Pathway Certification (Do not abbreviate)

City

State

From*: (Month) 19 (Year) To: (Month) 19 (Year)

Exact Date Certificate was Awarded: (Month) (Day) 19 (Year)

AMERICAN UNIVERSITY OF THE CARIBBEAN - SCHOOL OF MEDICINE

TRANSCRIPT OF ACADEMIC RECORDS
P.O. BOX 400, PLYMOUTH, MONTSERRAT, WEST INDIES

Student Number	Student Name	Citizenship	Sex
[Redacted] 43172	GINDE, Savita Yeshawant	USA	Female

Address	Date of Birth	Place of Birth
3800 Joyce Ann Drive, Youngstown, Ohio 44511	February 16, 1970	Toledo, Ohio

Entrance Date	Graduation Date	Degree Conferred	
September 1993	June 7,1997	DOCTOR OF MEDICINE	Master of Science April 21, 1995

Course #	Title	Sem. Hrs.	Grade
September 1993 Semester			
100	Anatomy	10	P
108	Cell Biology and Histology	7	P
109	Embryology	2	H
January 1994 Semester			
210	Medical Terminology	2	H
212	Biochemistry	6	H
220	Biostatistics	1	H
221	Physiology I	5	H
252	Medical Microbiology I	3	H
360	Medical Psychology	5	H
May 1994 Semester			
323	Physiology II	5	P
354	Medical Microbiology II	6	P
329	Neuroscience I	6	P
September 1994 Semester			
415	Pharmacology	4	P
419	Genetics	4	H
444	Pathology	8	P
447	Neuroscience II	2	P
471	Preventive Medicine	1	H
January 1995 Semester			
534	Introduction to Clinical Medicine	8	H
546	Clinical Pathology	7	P
591	Biological Basis of Clinical Medicine	5	P

Course #	Title	Sem. Hrs.	Grade
September 1995 Semester			
	Medicine (Family Practice)	6 weeks	P
January 1996 Semester			
	Psychiatry	6 weeks	H
	Internal Medicine	11 weeks	H
May 1996 Semester			
	Internal Medicine	1 week	H
	Medicine (Oncology/Hematology)	4 weeks	P
	(Neurology)	4 weeks	H
	Surgery	4 weeks	P
September 1996 Semester			
	Surgery	8 weeks	P
	Obstetrics/Gynecology	6 weeks	H
	Pediatrics	3 weeks	P
January 1997 Semester			
	Pediatrics	3 weeks	P
	Medicine (Infectious Diseases)	4 weeks	P
	Surgery (Pathology)	4 weeks	H
	(Anesthesiology)	4 weeks	P
May 1997 Semester			
	Medicine (Opthamology)	4 weeks	H

Dorothy M. Chertok, Registrar

KEY: H-Honor 100-90%. P-Pass 89-70%. F-Fail 69-0%. R-Repeat. W-Withdraw. This transcript is printed on a pink color safety paper and does not require a raised seal.

American University of the Caribbean

on the recommendation of the Faculty of the

School of Medicine

of the University, does hereby confer upon

Savita Yeshawant Ginde

the degree of

Doctor of Medicine

with all the rights and privileges appertaining thereto. Given at Plymouth, Montserrat, on June 7, 1997.

SEAL VERIFIED

Paul S. Tien
President of the University

Robert J. Chertok
Dean

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES
PHILADELPHIA OFFICE
3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.
TELEPHONE: 215 386-5900 ● FAX: 215 386-6327 ● INTERNET: www.ecfmg.org

Your **organization number** is: **V-02735**
Please include this number on all requests.

Date: January 19, 2001 *

To: KEVIN CALDWELL
MANAGER
FEDERATION CREDENTIALS VERIFICATION SERVICE
400 FULLER WISER ROAD
SUITE 300
EULESS, TX 76039-3855

CONFIRMATION OF ECFMG CERTIFICATION

USMLE/ECFMG Identification Number: 0-533-589-8 **Date ECFMG Certification was Issued:** 08/22/1997	Physicians who are ECFMG-certified have passed the requisite medical science examination and English language proficiency test and had their medical education credentials verified by ECFMG. Effective July 1, 1998, a passing score on the ECFMG Clinical Skills Assessment must also be achieved to be eligible for ECFMG certification. ECFMG certification is a prerequisite for entry into ACGME-accredited residency or fellowship programs in the United States; is required by most states for licensure to practice medicine in the United States; and is one of the eligibility requirements to take USMLE Step 3.
English Test is Valid Through: Valid Indefinitely	In the event that the English test date has expired, an applicant will be required to pass a subsequent ECFMG English test or demonstrating a performance acceptable to ECFMG on TOEFL. If the CSA date has expired, an applicant will be required to pass a subsequent CSA After an applicant enters an ACGME-accredited program of graduate medical education in the United States, the English test and CSA valid-through dates are no longer subject to expiration.
Physician Name: Savita Yeshawant Ginde **Date of Birth:** 02/16/1970	This is the information found in ECFMG computer records that correlates with the above USMLE/ECFMG Identification Number. It is the responsibility of the requesting organization to obtain appropriate documentation (e.g. marriage license, record of official name change, birth certificate, etc.) from the physician to validate any discrepancy with the name and/or date of birth as they appear in ECFMG records.

* Information is current as of this date.

Important Note:
Requesting organizations must secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

V-02735 :4877
Form 236B - 08/98

ECFMG℠ is an organization committed to promoting excellence in international medical education

9437 591 2698 LC14

EDUCATIONAL COMMISSION
for
FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

SAVITA YESHAWANT GINDE

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY PASSED ITS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER 0-533-589-8

MEDICAL EXAMINATION

BASIC SCIENCE SEPTEMBER 28, 1995

CLINICAL SCIENCE MARCH 05, 1997

ENGLISH EXAMINATION MARCH 05, 1997

VALID THROUGH

CERTIFICATE NUMBER
0-533-589-8
ENGLISH EXAMINATION
March 5, 1997
VALID INDEFINITELY

CHAIRMAN, BOARD OF TRUSTEES

PRESIDENT, CHIEF EXECUTIVE OFFICER

DATE ISSUED AUGUST 22, 1997

Section IV

Postgraduate Training

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

(This form must be completed by the Program Director)

INSTRUCTIONS TO THE PROGRAM DIRECTOR

The individual identified on the attached Authorization For Release of Information, D[illegible] form has authorized your postgraduate training program to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it, together with an official copy of the individual's record (indicating rotations, dates, and hours of training, scores, grades or evaluations), to FCVS in the enclosed postage-paid, self-addressed envelope.**

POSTGRADUATE MEDICAL EDUCATION HISTORY

Name of Institution: Mount Sinai Medical Center of Cleveland

Complete Address: DEPARTMENT OF INTERNAL MEDICINE
Street Address
ONE Mt. SINAI DRIVE
Street Address
CLEVELAND OH 44106-4198
City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

Name and complete address of affiliated university/college: CASE WESTERN RESERVE UNIVERSITY
Institution
10900 EUCLID AVENUE
Street Address
Street Address
CLEVELAND OH 44106
City State Zip Code(Postal Code)

Enrollment and Participation: Our records indicate that GINDE, SAVITA Y.
(type/print individual's name: Last, First, Middle, Suffix)

participated in the following:

Program Type (Internship, Residency, Fellowship)	PGY (1,2,3,4)	Department (Pathology, Internal Medicine, etc.)	Dates Attended (month/day/year) From	To	Completed (Yes/No)	Accredited By (ACGME, RSC, AOA or Not Accredited)
TRANSITIONAL	1	INT. MED.	07/01/98	06/30/99	YES	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response.

Questions	Response	
Did this individual ever take a leave of absence or break from their medical education?	Yes	(No)
Was this individual ever placed on probation?	Yes	(No)
Was this individual ever disciplined or under investigation?	Yes	(No)
Were any negative reports regarding this individual ever filed by instructors?	Yes	(No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes	(No)

"Yes" responses to any of the questions above concerning unusual circumstances require a written explanation.

Certification: By my signature below, I, D. ROY FERGUSON, M.D. (type/print name), certify that the information contained in this report is an accurate account of the above named individual's official records maintained by this institution and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized.)

SEAL VERIFIED

Signature: DR Ferguson

Title: PROGRAM DIRECTOR

Date of Signature: 07/06/99

Telephone: (216) 421-3983

July 2, 1999

TO WHOM IT MAY CONCERN:

RE: SAVITA GINDE, M.D.

PHS

Mt. Sinai
Medical Campus
University Circle

Neighborhood
Commitment. Specialized
Care.

INTERNAL MEDICINE
RESIDENCY TRAINING
PROGRAM

This will verify that Savita Ginde, M.D. was a Transitional Resident at Mt. Sinai Medical Center in Cleveland, Ohio from July 1, 1998 to June 30, 1999. Dr. Ginde's rotation is as follows:

July 1998	Urology
August 1998	Ophthalmology
September 1998	General Medicine
October 1998	General Medicine
November 1998	Emergency Services
December 1998	Ophthalmology
January 1999	Medical Intensive Care
February 1999	Radiology
March 1999	Surgery
April 1999	Infectious Disease
May 1999	Obstetrics/Gynecology
June 1999	Obstetrics/Gynecology

If further information is needed, please do not hesitate to call.

Sincerely,

D. Roy Ferguson, M.D.
Program Director

ONE MT. SINAI DRIVE
CLEVELAND, OHIO
44106-4198

216.421.5768 *phone*
216.421.4833 *fax*

Federation Credentials Verification Service (FCVS)
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **New Hampshire Dartmouth Family Practice Residency-Concord**
Address: 250 Pleasant Street
Concord, NH 03301

Attention: Department of Family Practice
Affiliated University: _____

Verification For:

Name: **Ginde, Savita Yeshawant**
SSN: Redacted
DOB: **02/16/1970**

Physician's Name on Record (If different from above): _____

Program Participation:
Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per department. If the department is rotating or transitional, please provide a schedule of rotations.

PGY: _____ ___ Internship ___ Residency ___ Fellowship ___ Research
Department: _____
From: __/__/____ To: __/__/____
Successfully Completed?: ___Yes ___No ___In Progress
Accredited by: __ACGME __AOA __Not Accredited Other: _____

PGY: 2 ___ Internship ↘ Residency ___ Fellowship ___ Research
Department: NH-Dartmouth Family Practice Residency
From: 06/28/1999 To: 06/30/2000
Successfully Completed?: ↘ Yes ___No ___In Progress
Accredited by: ↘ ACGME __AOA __Not Accredited Other: _____

PGY: 3 ___ Internship ↘ Residency ___ Fellowship ___ Research
Department: NH-Dartmouth Family Practice Residency
From: 07/01/2000 To: 06/30/2001
Successfully Completed?: ___Yes ___No ↘ In Progress
Accredited by: ↘ ACGME __AOA __Not Accredited Other: _____

Unusual Circumstances:
Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue you explanation on a separate sheet of pap

Did this individual ever take a leave of absence or break from their training?	Yes (No)
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or placed under investigation?	Yes (No)
Were any negative reports ever filed by instructors?	Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes (No)

Please explain any "Yes" response from above:
_____
_____

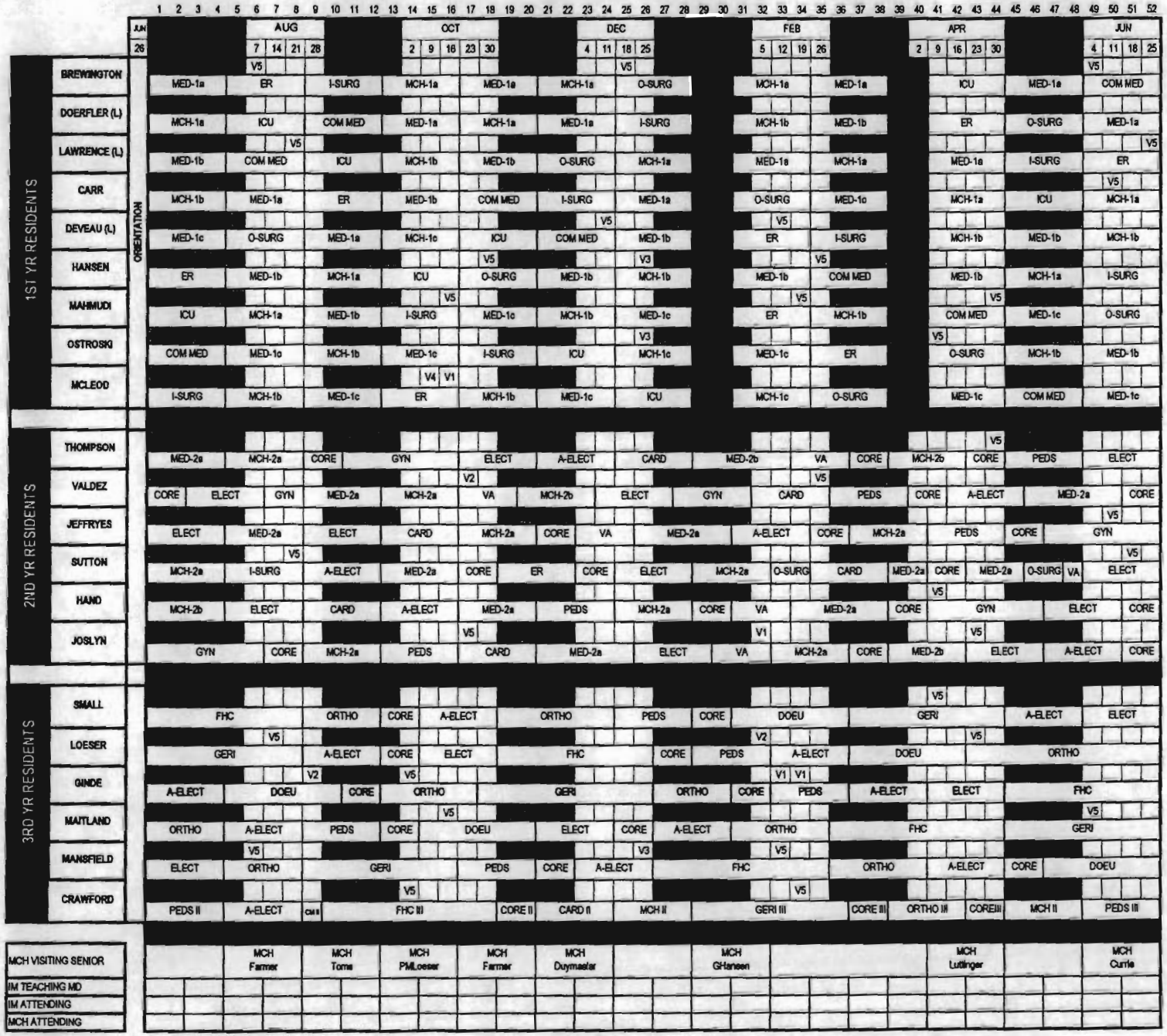
SEAL VERIFIED

Certification:
Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: Daniel F. Eubank MD Signature: _____
Title: Program Director Date of Signature: 1/13/01
Tel: 603-225-2711 x4790 Fax: 603-228-7173 E-Mail: deubank@crhc.org

CURRICULUM ROTATIONS 2000-2001



MAJOR HOLIDAYS

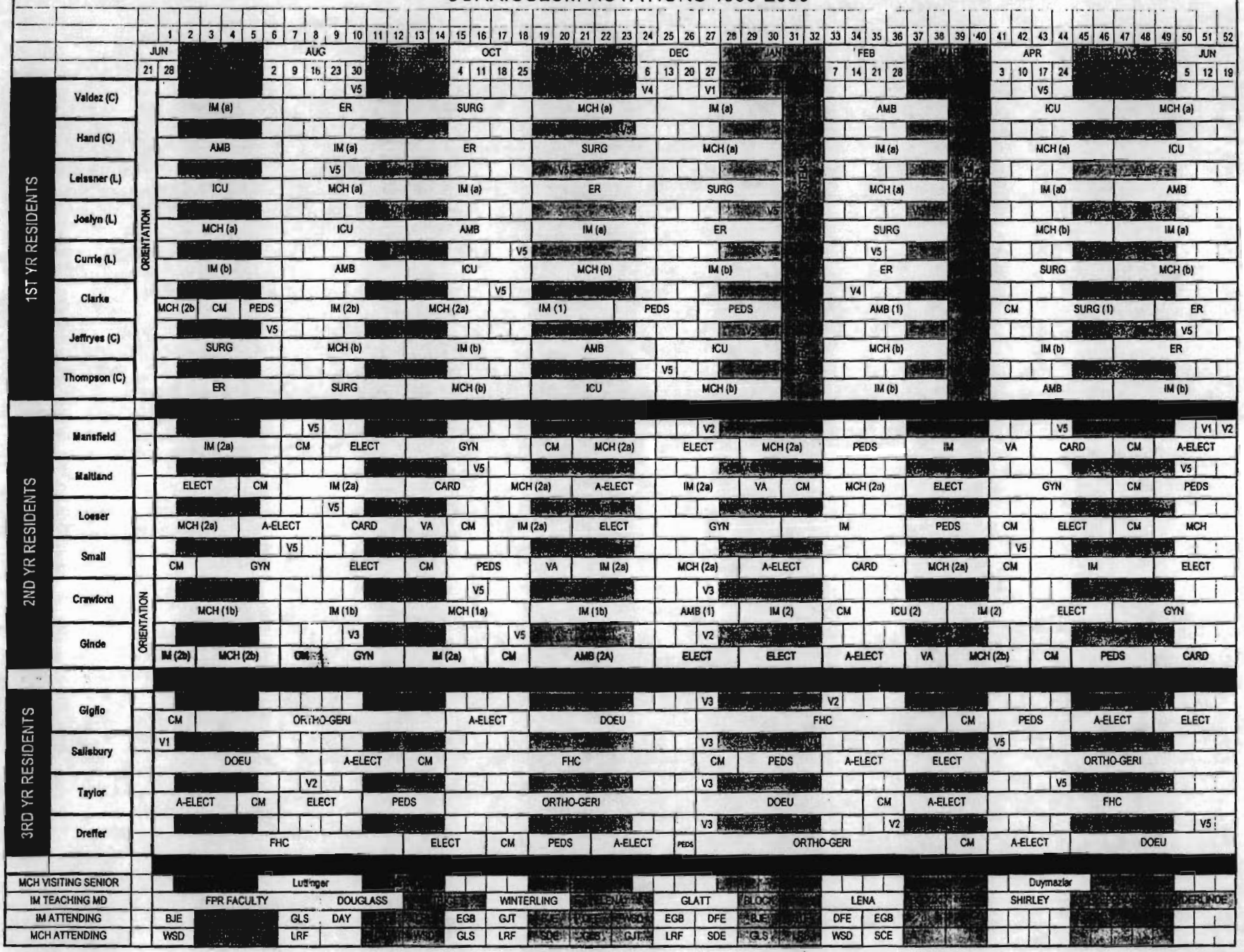
07/04/2000
09/04/2000
11/23/2000
12/25/2000
01/01/2001
05/28/2001

MINOR HOLIDAYS

10/09/2000
11/24/2000
01/15/2001
02/19/2001
05/28/2001

Revised 06/27/2000 3:01 PM

CURRICULUM ROTATIONS 1999-2000



F:\FAMPRAC\Curriculum 1999-2000\Resident Rotation Sched 99-00 REV A

Revised ~~03/31/2000~~

Section V

Examination History/Score Transcripts

USMLE
United States Medical Licensing Examination™

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 01/10/2001

Federation Credentials Verification Service
ATTN: Ohio

Examinee: Ginde, Savita Yeshawant
USMLE ID#: 0-533-589-8
DOB: 02 / 16 / 1970
Alt Name(s): Ginde, Savita

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1 Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
9/27/1995	PASS	179	(176)	75	(75)	
6/14/1995	FAIL	175	(176)	74	(75)	

STEP2 Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
3/3/1997	PASS	170	(170)	75	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
OHIO	9/25/2000	PASS	197	(177)	81	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

See reverse side for explanation of information reported above.

9437 5912698 LG14

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination (USMLE) scores is printed on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The embossed USMLE seal in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE Transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

TO TEST FOR AUTHENTICITY: When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT** will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

USMLE Transcripts include a complete score history and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 145 and 260. An equivalent value score on two-digit scale is also provided. A score of 82 on the two-digit e is equivalent to a score of 200 on the three-digit scale. A of 75 on the two-digit scale is the recommended minimum g score. The recommended minimum passing score on scale is shown on the front of the transcript next to the inee's score for each examination administration. The l of proficiency required to meet the recommended nimum passing level for each USMLE Step is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 7 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.**

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. To obtain information regarding the nature of the irregular behavior and the determination of the Committee, contact the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE Transcript by a "Note".

EDUCATIONAL COMMISSION
for
FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

SAVITA YESHAWANT GINDE

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY PASSED ITS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER	0-533-589-8
MEDICAL EXAMINATION	
BASIC SCIENCE	SEPTEMBER 28, 1995
CLINICAL SCIENCE	MARCH 05, 1997
ENGLISH EXAMINATION	MARCH 05, 1997
VALID THROUGH	

CERTIFICATE NUMBER
0-533-589-8
ENGLISH EXAMINATION
March 5, 1997
VALID INDEFINITELY

CHAIRMAN, BOARD OF TRUSTEES

PRESIDENT, CHIEF EXECUTIVE OFFICER

DATE ISSUED AUGUST 22, 1997

American University of the Caribbean

on the recommendation of the Faculty of the

School of Medicine

of the University, does hereby confer upon

Savita Yeshawant Ginde

the degree of

Doctor of Medicine

with all the rights and privileges appertaining thereto. Given at Plymouth, Montserrat, on June 7, 1997.

AMERICAN UNIVERSITY OF THE CARIBBEAN · 1978 ·

Paul S. Tien
President of the University

Robert J. Chertok
Dean

AMERICAN UNIVERSITY OF THE CARIBBEAN - SCHOOL OF MEDICINE

TRANSCRIPT OF ACADEMIC RECORDS

P.O. BOX 400, PLYMOUTH, MONTSERRAT, WEST INDIES

Redacted

Student Number	Student Name	Citizenship	Sex
43172	GINDE, Savita Yeshawant	USA	Female

Address	Date of Birth	Place of Birth
3800 Joyce Ann Drive, Youngstown, Ohio 44511	February 16, 1970	Toledo, Ohio

Entrance Date	Graduation Date	Degree Conferred	
September 1993	June 7,1997	DOCTOR OF MEDICINE	Master of Science April 21, 1995

Course #	Title	Sem. Hrs.	Grade
September 1993 Semester			
100	Anatomy	10	P
108	Cell Biology and Histology	7	P
109	Embryology	2	H
January 1994 Semester			
210	Medical Terminology	2	H
212	Biochemistry	6	H
220	Biostatistics	1	H
221	Physiology I	5	H
252	Medical Microbiology I	3	H
360	Medical Psychology	5	H
May 1994 Semester			
323	Physiology II	5	P
354	Medical Microbiology II	6	P
329	Neuroscience I	6	P
September 1994 Semester			
415	Pharmacology	4	P
419	Genetics	4	H
444	Pathology	8	P
447	Neuroscience II	2	P
471	Preventive Medicine	1	H
January 1995 Semester			
534	Introduction to Clinical Medicine	8	H
546	Clinical Pathology	7	P
591	Biological Basis of Clinical Medicine	5	P

Course #	Title	Sem. Hrs.	Grade
September 1995 Semester			
	Medicine (Family Practice)	6 weeks	P
January 1996 Semester			
	Psychiatry	6 weeks	H
	Internal Medicine	11 weeks	H
May 1996 Semester			
	Internal Medicine	1 week	H
	Medicine (Oncology/Hematology)	4 weeks	P
	(Neurology)	4 weeks	H
	Surgery	4 weeks	P
September 1996 Semester			
	Surgery	8 weeks	P
	Obstetrics/Gynecology	6 weeks	H
	Pediatrics	3 weeks	P
January 1997 Semester			
	Pediatrics	3 weeks	P
	Medicine (Infectious Diseases)	4 weeks	P
	Surgery (Pathology)	4 weeks	H
	(Anesthesiology)	4 weeks	P
May 1997 Semester			
	Medicine (Opthamology)	4 weeks	H

GRADING SYSTEM: H-Passed with honor, P-Passed, F-Failure, I-Incomplete, W-Withdrew, R-Repeat

OCT 22 1997

NOT VALID WITHOUT SEAL AND SIGNATURE OF SCHOOL OFFICIAL

OC
SEC/LAW

STATE ... DEC 26 2000

MEDICINE OR OSTEOPATHIC MEDICINE
PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	GINDE	SAVITA	YESHAWANT	

High School or Equivalent

School Name	City	State	Country	Dates Attended From: MO/YR	Dates Attended To: MO/YR
VILLA MARIA HIGH SCHOOL	VILLA MARIA	PA	USA	8/84	6/88

Undergraduate College or Equivalent

School Name	City	State	Country	Dates Attended From: MO/YR	Dates Attended To: MO/YR	Degree Received
UNIVERSITY OF PENNSYLVANIA	PHILADELPHIA	PA	USA	8/88	5/92	BA
School Name	City	State	Country	Dates Attended From: MO/YR	Dates Attended To: MO/YR	Degree Received
				/	/	

Medical or Osteopathic School of Graduation

School Name	City	State	Country	Dates Attended From: MO/YR	Dates Attended To: MO/YR	Degree Received
AMERICAN UNIVERSITY OF THE CARIBBEAN	MONTSERRAT	BRITISH WEST INDIES, LEEWARD ISLS		8/93	6/97	MD, MS

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 99038 DATE ISSUED: FEB 06 2001

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

Kay Rieve
Entrance Examiner

Anand G. Garg
Secretary

STATE BOARD
DEC 26 2000

MEDICINE OR OSTEOPATHIC MEDICINE
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 considered incomplete.

ss STATE OF: New Hampshire
COUNTY OF: Merrimack

I, SAVITA YESHAWANT GINDE, 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 application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor 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 a license to practice medicine or osteopathic 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 will be privileged.

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change occours at any time prior to a license to practice medicine or osteopathic medicine being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a license to practice medicine or osteopathic medicine 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 of 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 issuance of a certificate to practice medicine or osteopathic medicine in Ohio will be considered based on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

S. Gindе
Signature of Applicant

Subscribed and sworn to before me this 21st day of November 2000.

(NOTARY SEAL)

Kathleen A. Cesere
Signature of Notary Public
KATHLEEN A. CESERE, Notary Public
My Commission Expires November 20, 2001
Date Commission Expires

FOR BOARD USE ONLY

NAME:_____

CERTIFICATE NO.:_____

DATE ISSUED:_____, 20_____

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE OR OSTEOPATHIC MEDICINE

FILED: _____, 20_____

DETERMINATION:

BOARD ACTION:

5-14-53

MEDICINE OR OSTEOPATHIC MEDICINE - PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

NAME:

LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
GINDE	SAVITA	YESHAWANT	

HIGH SCHOOL OR EQUIVALENT:

SCHOOL NAME		
VILLA MARIA HIGH SCHOOL		
CITY	**STATE**	**COUNTRY**
VILLA MARIA	PA	USA

DATES ATTENDED: FROM: MO/YR 9/84 TO: MO/YR 6/88

UNDERGRADUATE COLLEGE OR EQUIVALENT:

SCHOOL NAME		
UNIVERSITY OF PENNSYLVANIA		
CITY	**STATE**	**COUNTRY**
PHILADELPHIA	PA	USA

DATES ATTENDED: FROM: MO/YR 9/88 TO: MO/YR 6/92 DEGREE RECEIVED: BA

RJ 13 RM

SCHOOL NAME		
CITY	**STATE**	**COUNTRY**

DATES ATTENDED: FROM: MO/YR / TO: MO/YR / DEGREE RECEIVED:

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:

SCHOOL NAME		
AMERICAN UNIVERSITY OF THE CARIBBEAN		
CITY	**STATE**	**COUNTRY**
~~CORAL GABLES~~ Montserrat West Indies	~~FL~~	USA

DATES ATTENDED: FROM: MO/YR 8/93 TO: MO/YR 6/97 DEGREE RECEIVED: MS + MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 95978 DATE ISSUED: APR 12 1999

95 FEB -1 PM 12:39 STATE MEDICAL BOARD

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

Ray L Bumgarner
Entrance Examiner

Anand G. Garg Jr.
Secretary

Revised 05/20/97

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

DATE: 4/7/99

Dear Doctor:

Dr. Savita Yeshawant Ginde , MD who is/was Resident Transitional/Medicine 7/98 - present is applying to sit for 5/11-12/99 USMLE Step 3 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 the examination. ***To ensure processing of the physicians application please complete this form and return to the Ohio State Medical Board within two (2) weeks by either mail or FAX.*** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Information provided is considered confidential under Section 149.42 (A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known him/her? 9 mos

(2) What is/was your supervisory capacity? Dept Chairman / Prog. Director

(3) At what hospital? Mt. Sinai Medical Center

(4) How would you rate his/her medical knowledge and techniques? Above average

(5) In your opinion is he/she a person of good moral and ethical character? yes

(6) Does he/she 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)? U.S. citizen excellent

(9) Would you recommend him/her to take the examination? yes

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

Sincerely,

Penny E. Grubb

Penny E. Grubb
Chief, Licensure

D. Ray Ferguson

Signature of Physician

D. Ray Ferguson MD

Name of Physician (please type or print clearly)

Dept. Chairman & Program Director

Position

216-421-3983

Telephone number (include area code)

1999 MAY -3 AM 9:46

STATE MEDICAL BOARD OF OHIO

Direct Dial: (614) 466-9234
FAX: (614) 644-1464

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Savita Yeshawant Ginde**
SSN:	Redacted
DOB:	**02/16/1970**
Recipient:	**State Medical Board of Ohio**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

The Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. The Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Savita Yeshawant Ginde**	
Other Name Used:	**N/A**	
Gender:	**Female**	
Date of Birth:	**02/16/1970**	
Place of Birth:	**Toledo, OH**	
SSN:	Redacted	
Current Address:	**30 Severance Circle, Apt. 720** **Cleveland Heights, OH 44118-5506**	
Permanent Address:	**3800 Joyce Ann Drive** **Youngstown, OH 44511**	
Telephone Numbers:	Bus.:	**(216) 421-4433PG2385**
	Fax:	**N/A**
	Home:	**(216) 291-3450**
	Other:	**N/A**
Physical Description:	Height:	**5' 08"**
	Weight:	**125 lbs**
	Eye Color:	**Dark Brown**
	Hair Color:	**Dark Brown**
Physical Marks:	Location:	**Right Forehead**
	Description:	**Mole**

Premedical Education (Reported by physician. Not verified by FCVS)**:**

Institution:	**University of Pennsylvania** **3451 Walnut Street** **Franklin Building** **Philadelphia, PA 19104-6291**
Dates of Attendance:	**09/1988 - 05/1992**
Degree Awarded:	**Bachelor of Arts**
Institution:	**University of Cincinnati** **103 Beecher Hall** **Cincinnati, OH 45221-0060**
Dates of Attendance:	**09/1992 - 06/1993**
Degree Awarded:	**Did not Graduate**

Medical Education:

Current, valid ECFMG	**Yes**
ECFMG Number:	**05335898**

Date Issued:	**08/22/1997**
Medical School:	**School of Medicine, American University of the Caribbean** **901 Ponce de Leon, Suite 201** **Coral Gables, FL 33134**
Dates of Attendance:	**08/30/1993 - 06/07/1997**
Graduation Date:	**06/07/1997**
Degree Awarded:	**Doctor of Medicine**
Unusual Circumstance:	**Leave** **See Form**

Post Graduate Medical Education:

Institution:	**Mount Sinai Medical Center of Cleveland** **Department of Medical Education** **One Mt. Sinai Drive** **Cleveland, OH 44106-4198**
Post Graduate Year:	**1**
Program Type:	**Transitional**
Department:	**Internal Medicine**
Dates of Attendance:	**07/01/1998 - 06/30/1999**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Clinical Clerkships:

N/A

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Omission / Discrepancy Report

Physician Identification:

Name:	Savita Yeshawant Ginde
DOB:	02/16/1970
SSN:	Redacted
Packet ID:	9437

REPORT OF OMISSIONS

There are no omissions in this physician's FCVS file.

REPORT OF DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Medical Education**
FCVS Interpretation:	The applicant reports no unusual circumstances during attendance at American U Of Caribbean (documentation provided). The institution reports Leave.
Solution:	Took leave for studies.

End of report for Savita Yeshawant Ginde

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name:	**Ginde, Savita Yeshawant**
Date of Birth:	**02/16/1970**
Medical School:	**654010 - American U Of Caribbean**
Year of Graduation:	**1997**
Social Security Number:	Redacted
ECFMG Number:	**0-533-589-8**

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

AUG 19 1999

James R. Winn, M.D.

JAMES R. WINN M.D.
EXECUTIVE VICE PRESIDENT

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make are true, that I am the person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies I furnish with my application are strictly true.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize every person, hospital, clinic, government agency (local, state, federal or foreign), institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, or true and correct copies of documents or records.

I hereby release, discharge and hold harmless the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, records or documents of any and all liability. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

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

GINDÉ
Applicant's Printed Last Name

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

January 18, 1999
Date of Signature (must correspond to date of notarization)

State of Ohio, County of Cuyahoga,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 18th day of January, 1999.

Notary Public signature: [signature] Brenda H. Phoenix
Notary Public, State of Ohio - Cuy. Cty.
My Comm. Exp. 11-13-02

My commission expires: 11-13-02

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

PACKET ID:

The Secretary of State
of the United States of America
hereby requests all whom it may concern to permit the citizen/
national of the United States named herein to pass
without delay or hindrance and in case of need to
give all lawful aid and protection.

Le Secrétaire d'Etat
des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer
le citoyen ou ressortissant des Etats-Unis titulaire du présent passeport,
sans délai ni difficulté et, en cas de besoin, de lui accorder
toute aide et protection légitimes.

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE

NOT VALID UNTIL SIGNED

UNITED STATES OF AMERICA

PASSPORT
PASSEPORT
USA

Type/Catégorie: P
Code of issuing / code du pays émetteur: USA
PASSPORT NO./NO. DU PASSEPORT: 087456357

Surname / Nom: GINDE

Given names / Prénoms: SAVITA YESHAWANT

Nationality / Nationalité: UNITED STATES OF AMERICA

Date of birth / Date de naissance: 16 FEB/FEV 70

Sex / Sexe: F

Place of birth / Lieu de naissance: OHIO, U.S.A.

Date of issue / Date de délivrance: 01 MAR/MAR 99

Date of expiration / Date d'expiration: 28 FEB/FEV 09

Authority / Autorité: PASSPORT AGENCY
NEW ORLEANS

Amendments/ Modifications: SEE PAGE 24

P<USAGINDE<<SAVITA<YESHAWANT<<<<<<<<<<<<<<<<

0874563573USA7002162F0902285<<<<<<<<<<<<<<<8

By the signature and seal affixed hereto, the Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Name: G. L. P. Date: 4-12-99

Title: Credentials Verification Analyst

Follow Up Requested

VOID

081841

MAR 14 1997

I HEREBY CERTIFY THAT THIS IS AN EXACT COPY OF THE ORIGINAL RECORD WHICH IS REGISTERED AND PRESERVED IN VITAL STATISTICS, OHIO DEPARTMENT OF HEALTH. WITNESS MY SIGNATURE AND THE SEAL OF THE DEPARTMENT.

[signature]
REGISTRAR OF VITAL STATISTICS

OHIO DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF LIVE BIRTH

Dist. No. 48 | Registrar's No. 1605
Primary Reg. Dist. No. 4801 | Birth No. 134 - 70-033566

CHILD—NAME (First / Middle / Last)	DATE OF BIRTH (Month, Day, Year)	HOUR
Savita / Yeshawant / Ginde	2a. February 16, 1970	2b. 8:24 A. M.

SEX	THIS BIRTH —Single, twin, triplet, etc. (Specify)	IF NOT SINGLE BIRTH —Born first, second, third, etc. (Specify)	COUNTY OF BIRTH
Female	4a. Single	4b.	5a. Lucas

CITY, VILLAGE, OR LOCATION OF BIRTH	INSIDE CITY LIMITS (Specify yes or no)	HOSPITAL—NAME (If not in hospital, give street and number)
Toledo	5c. Yes	5d. Riverside Hospital

MOTHER—MAIDEN NAME (First / Middle / Last)	AGE (At time of this birth)	STATE OF BIRTH (If not in U.S.A., name country)
Padma / Prabha / Divekar	6b. 30	6c. India

RESIDENCE—STATE	COUNTY	CITY, VILLAGE, OR LOCATION	INSIDE CITY LIMITS (Specify yes or no)	STREET AND NUMBER
Ohio	7b. Lucas	7c. Toledo	7d. Yes	7e. 510 Stickney Ave.

FATHER—NAME (First / Middle / Last)	AGE (At time of this birth)	STATE OF BIRTH (If not in U.S.A., name country)
Yeshawant / Vasudevrao / Ginde	8b. 33	8c. India

INFORMANT'S NAME OR SIGNATURE	RELATION TO CHILD
9a. Yeshawant Vasudevrao Ginde	9b. Father

I certify that the above named child was born alive at the place and time and on the date stated above.	DATE SIGNED	ATTENDANT—M.D., D.O., midwife, other (specify)
SIGNATURE [signature]	10b. 3/25/70	10c. M.D.
CERTIFIER—NAME (Type or Print) Samuel Zuker, M.D.	MAILING ADDRESS (Street or R.F.D. No., City or Village, State, Zip) 10c. 424 W. Woodruff, Toledo, Ohio 43624	
REGISTRAR—SIGNATURE [signature]		DATE RECEIVED BY LOCAL REGISTRAR MAR 10 1970

Section III

Medical Education

RECEIVED JUN 0 1 1999

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: School of Medicine, American University of the Caribbean

Complete Address: Post Office Box 400
Street Address
Plymouth Montserrat
Street Address
British West Indies
City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

Enrollment and Participation: Our records indicate that Gindey, Savita Yeshawant
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 144 weeks of continuous on-campus education on the following dates (mm/dd/yy):

From	To
08 / 30 / 93	05 / 01 / 94
05 / 02 / 94	01 / 01 / 95
01 / 02 / 95	04 / 30 / 95
08 / 28 / 95	04 / 26 / 96
04 / 27 / 96	01 / 05 / 97
01 06 97	06 07 97

This individual (check one):

____ was awarded the degree of Doctor of Medicine on 06 / 07 / 97 (mm/dd/yy)

____ was NOT awarded a degree (please attach an explanation)

RECEIVED
JUN 2 8 1999
By

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response. **"Yes" responses to any of these questions requires a written explanation.**

Questions	Response
Did this individual ever take a leave of absence or break from their medical education? Study leave MK	(Yes) No
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or under investigation?	Yes (No)
Were any negative reports regarding this individual ever filed by instructors?	Yes (No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes (No)

Premedical Education: Does your school have a premedical education requirement? (Yes) No

If yes, include where your records indicate the individual completed his/her premedical education and the basic science courses taken (attach additional pages if necessary):

Premedical Institution(s): University of Pennsylvania
University of Cincinnati

Check Courses Taken: ___X___ Physics ___✓___ Biology/Zoology
___✓___ Organic Chemistry ___✓___ Inorganic Chemistry

Certification: By my signature, I, Yifa Tien (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized).

Signature: Yifa Tien

Title: Director

Date of Signature: 5/26/99

Telephone: (305) 446 0600

SEAL VERIFIED

Applicant: Print your complete last name: GINDE

14. Medical Education Outside the U.S or Canada

Complete this page only if you have attended a medical school located outside the U.S. or Canada.

List all of the medical schools you attended. You may photocopy this page to report more than one (1) institution, if necessary.

DOCUMENTATION:

You must include a legible photocopy of your medical school diploma.

AMERICAN UNIVERSITY OF THE CARIBBEAN

Complete Name of Medical School (Do not abbreviate)

Complete Name of Affiliated University or College (Do not abbreviate)

MEDICAL EDUCATION INFORMATION

Address Line 1

OFFICE 901 PONCE DE LEON BLVD

Address Line 2

CORAL GABLES

City

Province

33134036

Zip/Postal Code

USA

Country

Duration of medical degree program: From: 08 (Month) 1993 (Year) To: 06 (Month) 1997 (Year)

Duration of additional clinical training (if applicable): From: (Month) (Year) To: (Month) (Year)
(i.e., training required before degree is conferred)

Degree (as it appears on your diploma): ☐ MBBS ☐ MBBCh ☑ Other: MD
☐ Did Not Graduate

Exact Date Degree was Conferred: 06 (Month) 07 (Day) 1997 (Year)

Unusual Circumstances (circle Yes or No):

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8½ x 11 sheet of paper. Your response may not exceed 100 words per question.

Did you take a leave(s) of absence or break(s) from your medical education?	YES	(NO)
Were you ever placed on probation?	YES	(NO)
Were you ever disciplined or placed under investigation?	YES	(NO)
Were any negative reports ever filed against you?	YES	(NO)
Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems, or for any other reason?	YES	(NO)

Please explain any "Yes" response from above:

15. Fifth Pathway

Complete this section only if you participated in a Fifth Pathway Program.

DOCUMENTATION:

You must include a legible photocopy of your Fifth Pathway Certificate.

N/A

Complete Name of Medical School that Awarded Fifth Pathway Certification (Do not abbreviate)

City

State

From*: (Month) (Year) To: (Month) (Year)

Exact Date Certificate was Awarded: (Month) (Day) 19 (Year)

AMERICAN UNIVERSITY OF THE CARIBBEAN - SCHOOL OF MEDICINE

TRANSCRIPT OF ACADEMIC RECORDS
P.O. BOX 400, PLYMOUTH, MONTSERRAT, WEST INDIES

Student Number	Student Name	Citizenship	Sex
[redacted] 43172	GINDE, Savita Yeshawant	USA	Female

Address	Date of Birth	Place of Birth
3800 Joyce Ann Drive, Youngstown, Ohio 44511	February 16, 1970	Toledo, Ohio

Entrance Date	Graduation Date	Degree Conferred	
September 1993	June 7,1997	DOCTOR OF MEDICINE	Master of Science April 21, 1995

Course #	Title	Sem. Hrs.	Grade
September 1993 Semester			
100	Anatomy	10	P
108	Cell Biology and Histology	7	P
109	Embryology	2	H
January 1994 Semester			
210	Medical Terminology	2	H
212	Biochemistry	6	H
220	Biostatistics	1	H
221	Physiology I	5	H
252	Medical Microbiology I	3	H
360	Medical Psychology	5	H
May 1994 Semester			
323	Physiology II	5	P
354	Medical Microbiology II	6	P
329	Neuroscience I	6	P
September 1994 Semester			
415	Pharmacology	4	P
419	Genetics	4	H
444	Pathology	8	P
447	Neuroscience II	2	P
471	Preventive Medicine	1	H
January 1995 Semester			
534	Introduction to Clinical Medicine	8	H
546	Clinical Pathology	7	P
591	Biological Basis of Clinical Medicine	5	P

Course #	Title	Sem. Hrs.	Grade
September 1995 Semester			
	Medicine (Family Practice)	6 weeks	P
January 1996 Semester			
	Psychiatry	6 weeks	H
	Internal Medicine	11 weeks	H
May 1996 Semester			
	Internal Medicine	1 week	H
	Medicine (Oncology/Hematology)	4 weeks	P
	(Neurology)	4 weeks	H
	Surgery	4 weeks	P
September 1996 Semester			
	Surgery	8 weeks	P
	Obstetrics/Gynecology	6 weeks	H
	Pediatrics	3 weeks	P
January 1997 Semester			
	Pediatrics	3 weeks	P
	Medicine (Infectious Diseases)	4 weeks	P
	Surgery (Pathology)	4 weeks	H
	(Anesthesiology)	4 weeks	P
May 1997 Semester			
	Medicine (Opthamology)	4 weeks	H

Dorothy M. Chadok, Registrar

KEY: H-Honor 100-90%, P-Pass 89-70%, F-Fail 69-0%, R-Repeat, W-Withdraw. This transcript is printed on a pink color safety paper and does not require a raised seal

American University of the Caribbean

on the recommendation of the Faculty of the

School of Medicine

of the University, does hereby confer upon

Savita Yeshawant Gindé

the degree of

Doctor of Medicine

with all the rights and privileges appertaining thereto. Given at Plymouth, Montserrat, on June 7, 1997.

SEAL VERIFIED

AMERICAN UNIVERSITY OF THE CARIBBEAN · 1978 ·

Paul S. Tien
President of the University

Robert J. Chertok
Dean

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

PHILADELPHIA OFFICE

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.

TELEPHONE: 215-386-5900 | CABLE: EDCOUNCIL, PHA.

Your **organization number** is: **V-02735**
Please include this number on all requests.

Date: March 19, 1999 *

To: DAVID HILL
MANAGER
FEDERATION CREDENTIALS VERIFICATION SERVICE
400 FULLER WISER ROAD
SUITE 300
EULESS, TX 76039-3855

CONFIRMATION OF ECFMG CERTIFICATION

USMLE/ECFMG Identification Number: 0-533-589-8 **Date ECFMG Certification was Issued:** 08/22/1997	Physicians who are ECFMG-certified have passed the requisite medical science examination and English language proficiency test and had their medical education credentials verified by ECFMG. Effective July 1, 1998, a passing score on the ECFMG Clinical Skills Assessment must also be achieved to be eligible for ECFMG certification. ECFMG certification is a prerequisite for entry into ACGME-accredited residency or fellowship programs in the United States; is required by most states for licensure to practice medicine in the United States; and is one of the eligibility requirements to take USMLE Step 3.
English Test is Valid Through: Valid Indefinitely	In the event that the English test date has expired, an applicant will be required to pass a subsequent ECFMG English test or demonstrating a performance acceptable to ECFMG on TOEFL. If the CSA date has expired, an applicant will be required to pass a subsequent CSA After an applicant enters an ACGME-accredited program of graduate medical education in the United States, the English test and CSA valid-through dates are no longer subject to expiration.
Physician Name: Savita Yeshawant Ginde **Date of Birth:** 02/16/1970	This is the information found in ECFMG computer records that correlates with the above USMLE/ECFMG Identification Number. It is the responsibility of the requesting organization to obtain appropriate documentation (e.g. marriage license, record of official name change, birth certificate, etc.) from the physician to validate any discrepancy with the name and/or date of birth as they appear in ECFMG records.

* Information is current as of this date.

Important Note:
Requesting organizations must secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

ECFMG is an organization committed to promoting excellence in international medical education.

9437

EDUCATIONAL COMMISSION
for
FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

SAVITA YESHAWANT GINDE

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY PASSED ITS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER	0-533-589-8
MEDICAL EXAMINATION	
BASIC SCIENCE	SEPTEMBER 28, 1995
CLINICAL SCIENCE	MARCH 05, 1997
ENGLISH EXAMINATION	MARCH 05, 1997
VALID THROUGH	**CERTIFICATE NUMBER** 0-533-589-8 **ENGLISH EXAMINATION** March 5, 1997 **VALID INDEFINITELY**

CHAIRMAN, BOARD OF TRUSTEES

PRESIDENT, CHIEF EXECUTIVE OFFICER

DATE ISSUED AUGUST 22, 1997

Section IV

Postgraduate Training

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

(This form must be completed by the Program Director)

INSTRUCTIONS TO THE PROGRAM DIRECTOR

The individual identified on the attached Authorization For Release of Information, D[illegible] form has authorized your postgraduate training program to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it, together with an official copy of the individual's record (indicating rotations, dates, and hours of training, scores, grades or evaluations), to FCVS in the enclosed postage-paid, self-addressed envelope.**

POSTGRADUATE MEDICAL EDUCATION HISTORY

Name of Institution: Mount Sinai Medical Center of Cleveland

Complete Address: DEPARTMENT OF INTERNAL MEDICINE
Street Address
ONE Mt. SINAI DRIVE
Street Address
CLEVELAND OH 44106-4198
City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

Name and complete address of affiliated university/college: CASE WESTERN RESERVE UNIVERSITY
Institution
10900 EUCLID AVENUE
Street Address
Street Address
CLEVELAND OH 44106
City State Zip Code(Postal Code)

Enrollment and Participation: Our records indicate that GINDE, SAVITA Y.
(type/print individual's name: Last, First, Middle, Suffix)

participated in the following:

Program Type (Internship, Residency, Fellowship)	PGY (1,2,3,4)	Department (Pathology, Internal Medicine, etc.)	Dates Attended (month/day/year) From	To	Completed (Yes/No)	Accredited By (ACGME, RSC, AOA or Not Accredited)
TRANSITIONAL	1	INT. MED.	07/01/98	06/30/99	YES	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response.

Questions	Response	
Did this individual ever take a leave of absence or break from their medical education?	Yes	(No)
Was this individual ever placed on probation?	Yes	(No)
Was this individual ever disciplined or under investigation?	Yes	(No)
Were any negative reports regarding this individual ever filed by instructors?	Yes	(No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes	(No)

"Yes" responses to any of the questions above concerning unusual circumstances require a written explanation.

Certification: By my signature below, I, D. ROY FERGUSON, M.D. (type/print name), certify that the information contained in this report is an accurate account of the above named individual's official records maintained by this institution and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized.)

SEAL VERIFIED

Signature: DR Ferguson

Title: PROGRAM DIRECTOR

Date of Signature: 07/06/99

Telephone: (216) 421-3983

July 2, 1999

TO WHOM IT MAY CONCERN:

RE: SAVITA GINDE, M.D.

PHS

Mt. Sinai
Medical Campus
University Circle

Neighborhood
Commitment. Specialized
Care.

INTERNAL MEDICINE
RESIDENCY TRAINING
PROGRAM

This will verify that Savita Ginde, M.D. was a Transitional Resident at Mt. Sinai Medical Center in Cleveland, Ohio from July 1, 1998 to June 30, 1999. Dr. Ginde's rotation is as follows:

July 1998	Urology
August 1998	Ophthalmology
September 1998	General Medicine
October 1998	General Medicine
November 1998	Emergency Services
December 1998	Ophthalmology
January 1999	Medical Intensive Care
February 1999	Radiology
March 1999	Surgery
April 1999	Infectious Disease
May 1999	Obstetrics/Gynecology
June 1999	Obstetrics/Gynecology

If further information is needed, please do not hesitate to call.

Sincerely,

D. Roy Ferguson, M.D.
Program Director

ONE MT. SINAI DRIVE
CLEVELAND, OHIO
44106-4198

216.421.5768 *phone*
216.421.4833 *fax*

Section V

Examination History/Score Transcripts

USMLE
United States
Medical
Licensing
Examination

United States Medical Licensing Examination™
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 07/14/1999

Federation Credentials Verification Service
ATTN: Ohio

Examinee:	Ginde, Savita Yeshawant
USMLE ID#:	0-533-589-8
DOB:	02 / 16 / 1970
Alt Name(s):	Ginde, Savita

STEP1 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
9 /1995	PASS	179	176	75	75	
6 /1995	FAIL	175	176	74	75	

STEP2 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
3 /1997	PASS	170	170	75	75	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

See reverse side for explanation of information reported above.

9437
JP

Authenticity of USMLE™ Transcripts

Original, certified transcripts of United States Medical Licensing Examination (USMLE) scores are printed on blue safety paper and are produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The embossed USMLE seal in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history, and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For recent administrations, the mean and standard deviation of scores on the three-digit scale for first-time examinees from medical schools in the United States are approximately 205 and 20, respectively, and most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 82 on the two-digit scale is equivalent to a score of 200 on the three-digit scale. A score of 75 on the two-digit scale is always the minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each Step of USMLE is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 6 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

NOTATION REGARDING FSMB BOARD ACTION DATA BANK

The *Board Action Data Bank* of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. armed forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the *Bank*, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the *Board Action Data Bank* are <u>not</u> disciplinary or otherwise prejudicial in nature. Such actions are reported to assure records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Special circumstances in connection with the administration of an examination may result in one of the following annotations being listed next to the score for that examination:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

Incomplete - The examinee sat for some but not all of the scheduled test books. **No score is reported.**

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* To obtain information regarding the nature of the irregular behavior, the full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

Score Not Available -The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Testing Accommodations - Following review and approval of a request from the examinee, testing accommodations were provided in the administration of the examination.

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 [signature] Sept 2, 2002
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-07-9132-G	$305.00	10/01/02	01/01/03

SAVITA YESHAWANT GINDE,M.D.
3800 JOYCE ANN DRIVE
YOUNGSTOWN OH 44511

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
FP FAMILY PRACTICE

☒ **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.
3800 JOYCE ANN DRIVE
STREET
STREET
YOUNGSTOWN OH 44511
CITY STATE ZIP CODE
MAHONING
COUNTY

0935079132 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?* 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, 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 ☒

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, 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 ☒

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?*** YES ☐ NO ☒

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
☐ *Check this Box if you have NO principal Practice address.*
1000 SOUTH AVENUE STE.N348
Street
HIGHLAND HOSPITAL
Street
ROCHESTER NY 14618
City State Zip Code
MONROE
County

REQUIRED:
SOCIAL SECURITY NUMBER
Redacted

0991928002 711700
0033 017
1879132
1 SE 0000030500

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov/

VERIFICATION OF LICENSURE

This is to verify that the records of the State Medical Board Of Ohio contain the following information for the indicated licensee as of **7/7/2005:**

Identification Information

Name:	SAVITA YESHAWANT GINDE
Mailing Address:	3800 JOYCE ANN DRIVE, YOUNGSTOWN, OH 44511
Date of Birth:	02/16/1970
Place of Birth:	TOLEDO, OH
School of Graduation:	School of Medicine, American University of the Caribb
Date of Graduation:	06/07/97

License Information

Type of License:	Doctor of Medicine
License Number:	35 - 079132
How Issued:	End USMLE
Original Licensure Date:	03/09/2001
Expiration Date:	01/01/2005
Status:	INACTIVE

Formal Disciplinary Action: **No**
(If Formal Action is YES, see attached documents)

Debra L. Jones

Debra L.Jones
CME and Renewal Officer