APP-SENT
6/12/90

JUN 11 '90

STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

PLEASE TYPE OR PRINT CLEARLY

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

NAME: Lee (LAST (Surname)) Amy (FIRST) F (MIDDLE) (SUFFIX (Jr., II))

ADDRESS: 111 Whitehall Dr. (STREET & NUMBER) Tallmadge (CITY) OH (STATE) 44278 (ZIP) USA (COUNTRY)

TELEPHONE: BUSINESS: (216) 375-3000 (AREA CODE & NUMBER) HOME: (216) 630-3738 (AREA CODE & NUMBER)

BIRTH DATE: 6/18/64 (MO/DAY/YR) BIRTH PLACE: Pittsburgh (CITY) PA (STATE) USA (COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: Northeastern Ohio Universities College of Medicine (SCHOOL NAME) 4209 State Route 44 (STREET ADDRESS) Rootstown (CITY) OH (STATE) USA (COUNTRY)

9/184 (FROM: MO/DAY/YR) 5/188 (TO: MO/DAY/YR) M.D. (DEGREE RECEIVED) 5/28/88 (DATE RECEIVED: MO/DAY/YR)

OTHER MEDICAL SCHOOLS ATTENDED: (IF "NONE" ENTER "NONE")

NONE (SCHOOL NAME) (STREET ADDRESS) (CITY) (STATE) (COUNTRY)

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

(SCHOOL NAME) (STREET ADDRESS) (CITY) (STATE) (COUNTRY)

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

E.C.F.M.G. CERTIFICATE: YES ____ NO ✓ NUMBER ____ DATE ISSUED / /

FIFTH PATHWAY

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

ADDRESS: ____ (STREET & NUMBER) (CITY) (STATE) (ZIP) DATE: / / (FROM) / / (TO)

QUALIFYING EXAM TAKEN: ____ DATE: / /

POSTGRADUATE TRAINING

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

HOSPITAL: Akron City Hospital (NAME) 525 E. Market St (STREET ADDRESS) Akron (CITY) OH (STATE)
POSITION: PGY I & II DEPARTMENT: Ob/Gyn DATE: 7/88 (FROM: MO/YR) 6/90 (present) (TO: MO/YR)

HOSPITAL: ____ (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: ____ DEPARTMENT: ____ DATE: / / (FROM: MO/YR) / / (TO: MO/YR)

HOSPITAL: ____ (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: ____ DEPARTMENT: ____ DATE: / / (FROM: MO/YR) / / (TO: MO/YR)

HOSPITAL: ____ (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: ____ DEPARTMENT: ____ DATE: / / (FROM: MO/YR) / / (TO: MO/YR)

LICENSES IN OTHER COUNTRIES

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

COUNTRY:_____ ISSUE DATE: __/__/__ LICENSE #_____ CURRENT:YES__ NO__

COUNTRY _____ ISSUE DATE: __/__/__ LICENSE #_____ CURRENT:YES__ NO__

LICENSES IN THE UNITED STATES

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

STATE: OH ISSUE DATE: 3/19/89 LICENSE #: 030340 (temporary license) CURRENT:YES ✓ NO__

BASIS OF LICENSURE: NBME

STATE:_____ ISSUE DATE: __/__/__ LICENSE #:_____ CURRENT:YES__ NO__

BASIS OF LICENSURE:_____

STATE:_____ ISSUE DATE: __/__/__ LICENSE #:_____ CURRENT:YES__ NO__

BASIS OF LICENSURE:_____

STATE BOARD OR FLEX EXAMINATIONS TAKEN

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

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

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

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

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? PENDING ___ YES ✓ NO ___ DATE 3/89

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

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

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

A U.S. CITIZEN? YES ✓ NO ___ BASIS OF CITIZENSHIP_____ DATE: __/__

A GRADUATE OF A MEXICAN MEDICAL SCHOOL? YES ___ NO ✓ DATE __/__

DEGREE OBTAINED (CHECK ONLY ONE): ACTA_____ TITULO_____ MEDICO CIRUJANO_____

HAVE YOU ACHIEVED A SCORE OF AT LEAST TWO HUNDRED THIRTY (230) ON THE TEST OF SPOKEN ENGLISH OF THE EDUCATIONAL TESTING SERVICE AS REQUIRED UNDER SECTION 4731.09, O.R.C.? (THE TOEFL, ECFMG EXAM, etc., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TSE) YES ✓ (NBME) NO___

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

IF YES, GIVE FULL ADDRESS AT THAT TIME:

371 Tammery Dr. Tallmadge OH 44278
STREET ADDRESS CITY STATE ZIP

CERTIFICATION

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

Amy F. Lee 6/8/90
SIGNATURE DATE

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

60051

PRELIMINARY EDUCATION FORM

49-41

My name IN FULL is Lee (LAST) Amy (FIRST) Faye (MIDDLE)

High School or Equivalent:
Tallmadge H.S. (SCHOOL NAME) Tallmadge (CITY) OH (STATE) USA (COUNTRY)
9/79 (FROM: MO/YR) 5/82 (TO: MO/YR) high school diploma (DEGREE)

Undergraduate College or Equivalent:
University of Akron (SCHOOL NAME) Akron (CITY) OH (STATE) USA (COUNTRY)
6/82 (FROM: MO/YR) 8/84 (TO: MO/YR) B.S. (DEGREE)

(SCHOOL NAME) (CITY) (STATE) (COUNTRY)
/ (FROM: MO/YR) / (TO: MO/YR) (DEGREE)

Medical School of Graduation:
Northeastern Ohio Universities College of Medicine (SCHOOL NAME) Rootstown (CITY) OH (STATE) USA (COUNTRY)
9/84 (FROM: MO/YR) 5/88 (TO: MO/YR) M.D. (DEGREE)

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 77010

DATE ISSUED: 7/25/90

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

Karl L. Baumgarner
Entrance Examiner

[illegible] B. Crumbacher M.D.
Secretary

Ann Arbor
Ann Arbor City
7.9.90

APPLICATION FOR MEDICAL & OSTEOPATHIC LICENSURE

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

ALL RESPONSES MUST BE TYPED

1. SOCIAL SECURITY NUMBER _ Redacted _

2. FULL NAME (Use no initials) Lee (LAST (Surname)) Amy (FIRST) Faye (MIDDLE) (SUFFIX (Jr., II))

3. NAME (As you prefer it inscribed on your Ohio license) Lee (LAST (Surname)) Amy (FIRST) F. (MIDDLE) (SUFFIX (Jr., II))

4. ALTERNATE NAMES (IF "NONE" ENTER "NONE") NONE (LAST (Surname)) (FIRST) (MIDDLE) (SUFFIX (Jr., II))

5. CURRENT ADDRESS 111 Whitehall Dr. (STREET NUMBER & NAME)

Tallmadge (CITY) Ohio (STATE) 44278 (ZIP CODE) U.S.A. (COUNTRY)

6. PHYSICAL DESCRIPTION 5'2" (HEIGHT) 108 (WEIGHT) black (HAIR COLOR) brown (COLOR OF EYES) none (IDENTIFYING MARKS)

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

8. CITY IN OHIO WHERE YOU PLAN TO PRACTICE: Akron (CITY) OR (COUNTY)

PLANS OF PRACTICE: Will at least fulfill two more years of residency.

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

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

FOR OFFICE USE ONLY 34 [illegible] 35

1-7
49-41-120
6-26-90
153.00 pd 431

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

RESUME

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

Lee

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
a. 7 88 month year TO 6 90 month year	Akron City Hospital Hospital/University/Other 525 E. Market St., Akron, OH 44309 Street Address City/State Zip	Resident--OB/GYN	100	
b. month year TO month year	Hospital/University/Other Street Address City/State Zip			
c. month year TO month year	Hospital/University/Other Street Address City/State Zip			
d. month year TO month year	Hospital/University/Other Street Address City/State Zip			
e. month year TO month year	Hospital/University/Other Street Address City/State Zip			

JAN 21

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

ADDITIONAL INFORMATION

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

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

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

FORM 1

AMG

CERTIFICATE OF RECOMMENDATION

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

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, Charles Snyder, a licensed and practicing physician in the state of
Name of Recommending Physician

Ohio affirm that Amy F. Lee, has been known
Name of Applicant

to me personally and professionally for 2 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

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

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

Charles Snyder
Signature of Recommending Physician

Charles Snyder
Name of Recommending Physician
(Please print or type)

550 E. Market St
Akron Oh 44304
Address of Recommending Physician
(Include City, State, Zip)

(216) 535-2689
Telephone Number
(Include Area Code)

(SEAL)

Ohio 227036
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 19th day of June, 1990.

Elizabeth Lynn Hawkins
Notary Public

March 30, 1994
Date Commission Expires

PHO
STAPLE A
OF A
PHOTO

Upon completion return to:

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

Signature of Applicant

6/19/90
Date Photo Taken

21

FORM 1

CERTIFICATE OF RECOMMENDATION

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

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, PAUL D. GATEWOOD, M.D. a licensed and practicing physician in the state of
Name of Recommending Physician

Ohio affirm that Amy F. Lee, has been known
Name of Applicant

to me personally and professionally for 2 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: EXCELLENT
His/her command of the English language is: EXCELLENT
I rate his/her ability to work well with peers and medical staff as: EXCELLENT
His/her relationship with patients is: EXCELLENT.
Additional comments: AN EXCELLENT RESIDENT IN OBGYN

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

Signature of Recommending Physician

PAUL D. GATEWOOD, M.D.
Name of Recommending Physician
(Please print or type)

500 GRANT ST
AKRON OHIO 44311
Address of Recommending Physician
(Include City, State, Zip)

216-434-6255
Telephone Number
(Include Area Code)

(SEAL)

OHIO 33206
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 19th day of June, 1990.

Elizabeth Lynn Hawkins
Notary Public

March 30, 1994
Date Commission Expires

PHOTO

STAPLE A PHOTO OF AP

Upon completion return to:

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

Signature of Applicant

6/19/90
Date Photo Taken

21

STATE MEDICAL BOARD

FORM 2

90 JUN 21

CERTIFICATE OF POST-GRADUATE TRAINING

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

Dear Sir:

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

This certifies that Amy Lee (Name of Applicant) has rendered satisfactory and continuous service as a(n)

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

at Akron City Hospital (Name of Hospital). 525 E. Market St. Akron, Ohio (Complete Address of Hospital)

from 7/1/88 (beginning month/day/year) to 6/30/92 (ending month/day/year). It is

furtner certified that the above name
[ ] was awarded a certificate on
[ ] was not
[✓] will be awarded 6/30/92 (month/day/year)

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

John R. Karlen M.D.
Signature of Medical Director or Program Director
(Original signatures only, name stamps will not be accepted)

(SEAL OF HOSPITAL)

John R. Karlen, M.D.
Name (Please print or type)

6/19/90
Date

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

Upon completion return to:

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

AFFIDAVIT AND RELEASE

AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF Ohio

COUNTY OF Summit

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

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

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

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

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

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

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

Amy F. Lee
Signature of Applicant

Subscribed and sworn to before me this 19th day of June 1990.

Elizabeth Lynn Hawkins
Notary Public Signature

(NOTARY SEAL)

March 30 1994
Date Commission Expires

FEB 21 90

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO _____

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

Jay L. Baumgartner
Entrance Examiner

Henry B. Cramblett M.D.
[illegible] M.D.
Secretary

11-19-90
Date Issued

FOR BOARD USE ONLY

NAME: Lee, amy J.

CERTIFICATE #: 60851 DATE ISSUED 11-19-90

FILED June 12, 19 90

FEE _____

DETERMINATION:

BOARD ACTION:

BASIS OF LICENSURE:

AKRON CITY HOSPITAL

A Voluntary Nonprofit Hospital

Albert F. Gilbert, Ph.D.
President

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

May 7, 1990

April R. Davidson
Asst. to the Chief of Licensure
The Ohio State Medical Board
77 South High Street, 17th Floor
Columbus, Ohio 43215

Dear Ms. Davidson:

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

Mail to:

Amy Lee, M.D.
111 Whithall Drive
Tallmadge, Ohio 44278

S.F.
SENT
5/15/90

LEE, AMY

Thank you.

Sincerely,

Amy Lee, M.D.

STATE MEDICAL BOARD
90 MAY 14 PM 4:33

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

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Amy F. Lee, M.D.

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

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

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

Philadelphia, Pa.
07/01/89

Certificate # 354115

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from NORTHEASTERN OHIO UNIVS in MAY 1988 and whose birth date is 06/18/1964. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/86		
Anatomy	540	83
Physiology	405	75
Biochemistry	545	83
Pathology	490	80
Microbiology	560	84
Pharmacology	470	79
Behavioral Sciences	455	78
TOTAL TEST (Minimum Passing Score 380/75)	500	80
PART II passed 09/87		
Medicine	570	86
Surgery	610	88
Obstetrics and Gynecology	650	89
Public Health and Preventive Medicine	505	82
Pediatrics	625	88
Psychiatry	645	89
TOTAL TEST (Minimum Passing Score 290/75)	620	87
PART III passed 03/89		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	645	86
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		84

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

Melanie Valente
Secretary for Certification

SEAL

10/26/90
Date

Akron City

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

DATE July 9, 1990

Dear Doctor:

Dr. LEE, Amy Faye who is/was Resident /OB-GYN 7/88-present is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

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

(2) What was/is your supervisory capacity? Director of her residency program

(3) At what hospital? Akron City

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

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

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

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

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

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

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

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

April R Davidson
April Davidson
Licensure Assistant

John Karlen
Signature of Doctor, please type or print name legibly beneath

JOHN KARLEN MD

Chairman, Dept of Ob Gyn
Position

DATE: 7/13/90

Telephone No. 216-375-3124 (Include Area Code)

Northeastern Ohio Universities College of Medicine

Upon recommendation of the Faculty

and the Board of Trustees

Northeastern Ohio Universities College of Medicine

acting in concert with

University of Akron, Kent State University and Youngstown State University

hereby confers upon

Amy F. Lee

the degree of

Doctor of Medicine

with all the rights and privileges pertaining thereto

Given this twenty-eighth day of May, Nineteen hundred eighty-eight.

President, The University of Akron

President, Kent State University

Neil D Humphrey

President, Youngstown State University

Chairman, Board of Trustees
Northeastern Ohio Universities College of Medicine

Provost and Dean
Northeastern Ohio Universities College of Medicine

I HEREBY CERTIFY THAT I HAVE RECEIVED MY WALL CERTIFICATE

NUMBER 60851, ON 2/22/91
(Date)

Amy F. Lee
Name

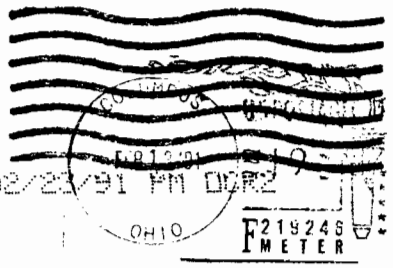
111 Whitehall Dr.
Street Address

Tallmadge, OH 44278
City State/County Zip

Signature

PLEASE CHECK IF THIS IS A CHANGE OF ADDRESS _____

MED 1013 (4/89)



State of Ohio
The State Medical Board
17th Floor
77 South High Street
Columbus, Ohio 43266-0315

STATE MEDICAL BOARD OF OHIO

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

MAY 26 93

Amy F. Lee, M.D.
347 W. Highland Rd.
Northfield, OH 44067

Dear Doctor:

Thank you for your prompt response to our request for audit material.

The results of this audit confirm that the continuing medical education materials you submitted for relicensure did indeed meet the Board's requirements.

The current and subsequent registration periods will end July 1, 1994, and July 1 of each even numbered year thereafter. It will be necessary to complete 100 credits with 40 being in Category I during each registration period. Licenses will expire on September 30 of each even numbered year. Please keep the Board informed of any address change.

Again, thank you for your cooperation.

Very truly yours,

Carla S. O'Day

Carla S. O'Day, M.D.
Secretary
State Medical Board of Ohio

CSO:jdc

Revised 04/05/93

LEE, Amy

OK

CERTIFICATION LOG OF CONTINUING MEDICAL EDUCATION FOR THE PERIOD OF JANUARY 1, 1991 - SEPTEMBER 30, 1992

I certify the following to be true and correct. This form must be completed, signed and returned.

SIGNATURE	DATE	OHIO CERTIFICATE NUMBER
	5/3/93	60851

NAME	(Last)	(First)	(Middle)	(Suffix, Jr., II)
	Lee	Amy	F.	

ADDRESS	(Number & street)	(City)	(State)	(Zip code)
	347 W. Highland Rd.	Northfield	Ohio	44067

93 MAY -6 AM 8:18

STATE MEDICAL BOARD

CATEGORY I

PLEASE ATTACH DOCUMENTATION

75 CREDIT REQUIREMENT

At least *30 credits* must be earned in Category I. Please list Category II credits on reverse side.

Name of Sponsor	Location (City & State)	Description	Date	Credits
Examples: Ohio State University Hosp.	**Columbus, Ohio**	**Pediatric Grand Rounds**	**12/01/91 thru 12/31/91**	**4**
Christ Hospital	**Cincinnati, Ohio**	**Surgery Residency**	**07/01/91 thru 06/30/92**	**50**
Akron City Hospital	Akron, OH	OB/GYN residency	7/1/88 to 6/30/92	50
Sinai Hospital	Detriot, MI	Colposcopy, Hysteroscopy, Cervical and Vulvar Pathology & Gynecologic Laser Surgery course	3/17/91 to 3/23/91	56.5
Johns Hopkins University School of Medicine	Baltimore, MD	Emil Novak Memorial course	10/14/91 to 10/19/91	51.75
NYU Medical Center	New York, NY	"Unresolved Issues: Hormone Replacement During Menopause"	3/25/92	2
Baylor College of Medicine	Houston, TX	"New Therapeutic Approaches to Sexually Transmitted Diseases"	4/26/92	3

Revised 01/13/93

OVER ⇨

CATEGORY II

A Maximum of ***45 credits*** may be earned in this Category.

Name of Sponsor	Location (City & State)	Description	Date	Credits
Examples: Riverside Hospital	**Toledo, Ohio**	**Internal Medicine Staff Meeting**	**10/21/91**	**8**
Self Instruction		**American Journal of Opthalmology**	**01/92 thru 09/92**	**60+**
Self instruction	Akron, Northfield, OH	Journal reading	1/1/91 to 9/30/92	50+

Revised 01/13/93

Akron City Hospital

Let it be known that

Amy F. Lee, M.D.

has completed a residency in

Obstetrics/Gynecology

from July first, nineteen hundred eighty-eight to June thirtieth, nineteen hundred ninety-two and has performed faithfully and satisfactorily.

Director of Medical Education

Residency Director

Chairman, Board of Trustees

President

A Teaching Hospital of the Northeastern Ohio Universities College of Medicine
A Member of Summa Health System

SINAI HOSPITAL

CONTINUING MEDICAL EDUCATION

6767 West Outer Drive
Detroit, Michigan 48235

This is to certify that:

Amy Lee
111 Whitehall Drive
Tallmadge, OH 44278

has participated in the following course:

Colposcopy, Hysteroscopy, Cervical and Vulvar Pathology and Gynecologic Laser Surgery

held on March 17-23, 1991 and is entitled to 56.5 hours credit in Category I.

Cheryl L. Poole

Cheryl L. Poole, Coordinator
Continuing Medical Education

The Johns Hopkins University
Office of Continuing Medical Education
720 Rutland Avenue / Baltimore, Maryland 21205

CERTIFICATE OF ATTENDANCE

(KEEP THIS CERTIFICATE FOR YOUR RECORDS)

ourse: 33rd Annual Emil Novak Memorial Course
lace: Turner Building, Baltimore, Maryland Date: October 14 - 19, 1991

MA Category I Credits: 53.5 hours, 51 cognates (ACOG), 5.3 CEUs
his program has been reviewed and is acceptable for 51.75 prescribed hours
y the American Academy of Family Physicians.

Amy F. Lee MD
371 Tammery Drive
Tallmadge OH 44278

(Physicians attending only a portion of the program should correct the number of hours to reflect the accurate number.)

Carol Johnsen Johns, M.D.
Director, Continuing Medical Education

The Johns Hopkins University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

NYU Medical Center
POST-GRADUATE
MEDICAL SCHOOL
A private university in the public service
550 First Avenue, New York, NY 10016
(212) 263-5295

To Whom It May Concern:

This is to certify that AMY LEE participated in "Unresolved Issues: Hormonal Replacement During Menopause" for the period of March 25, 1992. As an organization accredited for continuing medical education, the New York University Post-Graduate Medical School certifies that the above continuing medical education activity meets the criteria for 2 credit hours in Category I of the Physician's Recognition Award of the American Medical Association. The NYU Post-Graduate Medical School is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Robert J. Soberman, M.D.

Robert J. Soberman, M.D.
Associate Dean

NEW YORK UNIVERSITY POST-GRADUATE MEDICAL SCHOOL MDCCCXXXI

Amy Lee, M.D.

BAYLOR
COLLEGE OF
MEDICINE

One Baylor Plaza
Houston, Texas 77030-3498
Office of Continuing Education
Tel: (713) 798-4941
FAX: (713) 798-6600

This is to certify that **Amy Lee, M.D.**
has attended the continuing medical education activity

NEW THERAPEUTIC APPROACHES TO SEXUALLY TRANSMITTED DISEASES

April 26, 1992 **Las Vegas, Nevada**

Baylor College of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Baylor College of Medicine designates this continuing medical education activity for 3 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Sebastian Faro
Program Director

David M. Mumford M.D.
Associate Dean and Director
Office of Continuing Education

STATE MEDICAL BOARD OF OHIO

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

AMY F LEE
347 W HIGHLAND RD
NORTHFIELD OH 44067

Dear Doctor:

Upon renewal of your Ohio license to practice medicine and surgery, as of October 1, 1992, you certified that during the last registration period (January 1, 1991 - September 30, 1992) you had completed the requisite hours of Continuing Medical Education as certified by the Ohio State Medical Association and approved by the Board.

At this time, as a result of your being randomly selected for audit, it will be necessary for you to complete the enclosed log of Continuing Medical Education. It will also be necessary for you to provide the Board with documentation that you have actually completed at least 30 hours of Category I CME as certified on your license renewal application. Certificates of attendance, hospital printouts and accredited organization printouts are acceptable documentation, copies of which must be enclosed with your log. Those individuals desiring CME credits for their residency training program must submit either a copy of their certificate or a letter from the training program director giving the dates that they were in the program.

Up to forty-five hours of Category II credits may be listed on the reverse side of the log, but no documentation need be provided.

It is important you understand that under Ohio law it is your responsibility to document your CME participation, and, further that a failure to comply with the audit requirements can result in revocation or suspension of your license to practice in Ohio.

Please return the above requested material to the State Medical Board of Ohio within three weeks of receipt of this letter. The result of your log audit will be made available to you in the near future.

Thank you for your cooperation.

Sincerely,

Carla S. O'Day, M.D.
Secretary
State Medical Board of Ohio

CSO:jdc

Enclosures

CERTIFIED MAIL #
RETURN RECEIPT REQUESTED

Revised 04/05/93

LEE, AMY

Amy F. Lee
347 W. Highland Rd.
Northfield, OH 44067
Sept. 22, 1991
License number 60851

To Whom It May Concern:

This is a notification of change in address. My new home address is:

Amy F. Lee
347 W. Highland Rd.
Northfield, OH 44067

Thank you for your time.

updated
9.26.91
AC

Sincerely,

Amy Lee, MD

#60851

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X [signature] 6/27/92
(SIGNATURE OF APPLICANT) (DATE)

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

NOT ON FILE

[39] SPECIALTY CODE(S) CORRECT AS LISTED

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

CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0851	$160.00	07/01/92

AMY F LEE,M.D.
347 W HIGHLAND RD
NORTHFIELD OH 44067

⑆969696962⑆ 0935060851⑈ ⑈0000016000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
Street: 1120 McCRACKEN RD
Street: SUITE 351
City: GARFIELD HTS State: OH Zip Code: 44125
County: CUYAHOGA

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

A.) A felony or misdemeanor. YES NO ✓

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

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

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

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

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

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

Redacted
SOCIAL SECURITY NUMBER (Optional for purposes of identification)

333 00232 063092 01459 4 160.00 063092 935060851
TAX BATCH P DATE SEQ MC# AMOUNT BATCHDATE ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X _____ 6/23/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0851	$250.00	05/01/94

AMY F LEE,M.D.
347 W HIGHLAND RD
NORTHFIELD OH 44067

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

925 CLYDE AVE D
STREET
STREET
CUYAHOGA FALLS OH 44221
CITY STATE ZIP CODE
SUMMIT
COUNTY

:969696962: 0935060851 00000250000

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

Street
Street
City State Zip Code
County

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

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

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

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

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

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

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

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

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

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

MA× 883 00327 062994 015 MC# 42894 935060851
BATCH P DATE SENT AMOUNT BATCHDATE ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0851	$250.00	05/01/96

AMY F LEE,M.D.
925 CLYDE AVENUE D
CUYAHOGA FALLS OH 44221

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 0935060851 :00000250000:

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

Street
Street
City State Zip Code
County

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

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

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

383 00222 050296
TAX BATCH P DATE
250 00 042996
AMOUNT BATCHDATE
935060851
ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X _____ 3/20/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0851-L	$305.00	04/01/2000

AMY F LEE,M.D.
925 CLYDE AVENUE D
CUYAHOGA FALLS OH 44221

I wish to apply for Emeritus status: ☐

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY
MPH PUBLIC HEALTH & GEN PREVENTIVE MED

☑ *SPECIALTY CODE(S) CORRECT AS LISTED*

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935060851 :00000305 00:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

Street: 925 CLYDE AVE D
Street:
City: CUYAHOGA FALLS State: OH Zip Code: 44221
County: SUMMIT

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

	YES	NO
1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?	☐	☑
2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?	☐	☑
3.) Been addicted to or dependent upon alcohol or any chemical substance, or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.	☐	☑
4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?	☐	☑
5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?	☐	☑
6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances?	☐	☑
7.) Had any clinical privileges or other authority to practice suspended,restricted or revoked for reasons other than failure to maintain records or attend staff meetings?	☐	☑

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)
Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 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 _____ 3/19/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-0851-L	$305.00	04/04/02	07/01/02

AMY F LEE,M.D.
548 MORNINGSTAR DR
TALLMADGE OH 44278

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY
MPH PUBLIC HEALTH & GEN PREVENTIVE MED

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL
548 MORNINGSTAR DRIVE (STREET)
(STREET)
TALLMADGE (CITY) OH (STATE) 44278 (ZIP CODE)
SUMMIT (COUNTY)

0935060851 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.

4120 STEARNS ROAD 44
Street
P.O. BOX 035
Street
BOARDMAN OH 44236
City State Zip Code
MAHONING
County

REQUIRED: SOCIAL SECURITY NUMBER

Redacted

032220002 711700
1 0071035
060851
1 SE 0000030500

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION 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 _____ 3/25/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-0851-L	$305.00	04/01/04	07/01/04

AMY F LEE,M.D.
548 MORNINGSTAR DR
TALLMADGE OH 44278

0935060851 30500

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

MPH PUBLIC HEALTH & GEN PREVENTIVE MED

[X] SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

548 MORNINGSTAR DR
STREET
STREET
TALLMADGE OH 44278
CITY STATE ZIP CODE
SUMMIT
COUNTY

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 felony or misdemeanor? YES [ ] NO [X]

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

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

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

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

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

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

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

Street
Street
City State Zip Code
County

REQUIRED

Redacted

03292004 711700
0329 165
060851
4 SE 0000030500

Date Posted: 5/24/2006 10:07:04 AM

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

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

Address Information

BUSINESS ADDRESS	4209 STATE ROUTE 44 PO BOX 95 ROOTSTOWN, OH 44278 Portage County 330-325-6164
CREDENTIAL MAIL ADDRESS	548 MORNINGSTAR DR TALLMADGE, OH 44278 Summit County 330-929-4082

License Information

License Number	35.060851
License Name	AMY LEE
Email Address	

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   ..... PUBLIC HEALTH & GEN PREVENTIVE MED
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 3/25/2008 12:49:26 PM

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

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

License Information

License Number	35.060851
License Name	AMY LEE
Email Address	afl@neoucom.edu

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   ..... PUBLIC HEALTH & GEN PREVENTIVE MED
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

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

Discipline

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

reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 3/18/2010 10:02:44 AM

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

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

Address Information

BUSINESS ADDRESS

4209 STATE ROUTE 44
PO BOX 95
ROOTSTOWN, OH 44272
Portage County
330-325-6164
afl@neoucom.edu

License Information

License Number	35.060851
License Name	AMY LEE

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   ..... PUBLIC HEALTH & GEN PREVENTIVE MED
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

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

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 5/31/2012 9:52:06 PM

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

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

Address Information

BUSINESS ADDRESS	4209 STATE ROUTE 44 PO BOX 95 ROOTSTOWN, OH 44272 Portage County United States of America 330-325-6164 afl@neomed.edu
CREDENTIAL MAIL ADDRESS	548 MORNINGSTAR DR TALLMADGE, OH 44278 Summit County 330-929-4082 afl@neomed.edu

License Information

License Number	35.060851
License Name	AMY LEE

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below
   ..... PUBLIC HEALTH & GEN PREVENTIVE MED
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

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

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   ..... NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   ..... NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?
   ..... NO
5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**
   ..... NO
6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 0

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

. 0

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

. 0

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

. 25-29

5. "Volunteering" - providing medical and medical-related services at

no cost

. 0

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

. 30-34

Workforce Counties

1. Enter the first zip code:

. 44272

2. Enter the first county:

. . . . . Portage

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Public Health and General Preventive Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

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

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