APP-SENT 11/17/87

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: OBILISUNDAR (LAST (Surname)) NALINI (FIRST) ---- (MIDDLE) ----- (SUFFIX (Jr.,II))

ADDRESS: 1750A Treetop Trail (STREET & NUMBER) Akron (CITY) Ohio (STATE) 44313 (ZIP) U.S.A. (COUNTRY)

TELEPHONE: BUSINESS: (216) 384-6000 (AREA CODE & NUMBER) HOME: (216) 945-5630 (AREA CODE & NUMBER)

BIRTH DATE: 3 / 18 / 60 (MO/DAY/YR) BIRTH PLACE: Thirupur (CITY) Madras (STATE) India (COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: Ohio University Osteopathic Medical School (SCHOOL NAME) Athens, (STREET ADDRESS) OHIO (CITY) U.S.A. (STATE) (COUNTRY)

9 / / 84 (FROM: MO/DAY/YR) 6 / / 88 (TO: MO/DAY/YR) Doctor of Osteopathy (DEGREE RECEIVED) 6 / 11 / 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 X 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: Long Beach Memorial Hospital (NAME) 455 E.Bay St. (STREET ADDRESS) Long Beach, (CITY) N.Y. (STATE)
POSITION: Intern DEPARTMENT: Medicine / F.P. DATE: 7 / 88 (FROM: MO/YR) - 6 / 89 (TO: MO/YR)

HOSPITAL: Akron General Medical Center (NAME) 400 Wabash Ave. (STREET ADDRESS) Akron (CITY) Ohio (STATE)
POSITION: Resident DEPARTMENT: Psychiatry DATE: 7 / 89 (FROM: MO/YR) / 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)

LICENSES IN OTHER COUNTRIES

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

COUNTRY: NONE ISSUE DATE: / / LICENSE # CURRENT: YES NO

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

LICENSES IN THE UNITED STATES

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

STATE: NONE ISSUE DATE: / / LICENSE #: CURRENT: YES NO

BASIS OF LICENSURE:

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

BASIS OF LICENSURE:

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

BASIS OF LICENSURE:

STATE BOARD OR FLEX EXAMINATIONS TAKEN

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

STATE: Ohio-Part I DATE TAKEN: 11/86 PASS: X FAIL: FULL ( ) PARTIAL ( )

STATE: Ohio-Part II DATE TAKEN: 3/88 PASS: X FAIL: FULL ( ) PARTIAL ( )

STATE: N.Y.-PartIII DATE TAKEN: 3/89 PASS: X FAIL: FULL ( ) PARTIAL ( )

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

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

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

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

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

A U.S. CITIZEN? YES X NO BASIS OF CITIZENSHIP Naturalization DATE: 11/-/80 ?

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

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

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

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

IF YES, GIVE FULL ADDRESS AT THAT TIME:

STREET ADDRESS CITY STATE ZIP

CERTIFICATION

I, Nalini Obilisundar D.O., 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.

Nalini Obilisundar DO 11/9/89

SIGNATURE DATE

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

Akron
1-24-90
Long Beach
Akron Gen
AKRON 9/24/90

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): OBILISUNDAR (LAST (Surname)) NALINI (FIRST) ---- (MIDDLE) ---- (SUFFIX (Jr., II))

3. NAME (As you prefer it inscribed on your Ohio license): OBILISUNDAR (LAST (Surname)) NALINI (FIRST) ----- (MIDDLE) ----- (SUFFIX (Jr., II))

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

5. CURRENT ADDRESS: C/O Akron General Medical Center 400 Wabash Ave. (STREET NUMBER & NAME)
Akron (CITY) Ohio (STATE) 44307 (ZIP CODE) U.S.A. (COUNTRY)

6. PHYSICAL DESCRIPTION: 5'2" (HEIGHT) 116 (WEIGHT) black (HAIR COLOR) dk. brwn. (COLOR OF EYES) Mole under lower lip (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: Psychiatry - Adult

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

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

FOR OFFICE USE ONLY 34 35

1-7
86-29-7
9-17-90
1830 pm 320

SW 1 3

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.

OBili is under

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)	Long Beach Memorial Hospital Hospital/University/Other	Internship Transitional	100	
TO 6 / 89 (month / year)	P.O.Box 300 Long Beach, New York 11561 Street Address City/State Zip			
b. 7 / 89 (month / year)	Akron General Medical Center Hospital/University/Other	Psychiatry Resident	100	
TO Now (month / year)	400 Wabash Ave., Akron, OH 44313 Street Address City/State Zip			
c. (month / year)	Hospital/University/Other			
TO (month / year)	Street Address City/State Zip			
d. (month / year)	Hospital/University/Other			
TO (month / year)	Street Address City/State Zip			
e. (month / year)	Hospital/University/Other			
TO (month / year)	Street Address City/State Zip			

JUL 13

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]

JUL 1 3

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, John R. Combes, M.D., a licensed and practicing physician in the state of
Name of Recommending Physician
New York affirm that Nalini Obilisundar, D.O., 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: above average
His/her command of the English language is: excellent
I rate his/her ability to work well with peers and medical staff as: above average
His/her relationship with patients is: excellent
Additional comments:

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

John R Combes
Signature of Recommending Physician

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

Long Beach Memorial Hospital
455 East Bay Drive, Long Beach, NY 11561
Address of Recommending Physician
(Include City, State, Zip)

(516)- 432-8000 Ext #2580
Telephone Number
(Include Area Code)

New York, NY License #149396
State of Licensure and License Number
of Recommending Physician

(SEAL)

Subscribed and sworn to this 21st day of May, 1990.

Barbara Lohmer
Notary Public

BARBARA LOHMER, Notary Public
Residence - Summit County
State Wide Jurisdiction, Ohio
My Commission Expires July 31, 1994

Date Commission Expires

Upon completion return to:

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

Nalini Obilisundar DO
Signature of Applicant

5/25/90
Date Photo Taken

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, Jeffrey L. Moore, MD, a licensed and practicing physician in the state of
Name of Recommending Physician

Ohio affirm that Nalini Ohlisundar, has been known
Name of Applicant

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

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

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

Jeffrey L. Moore, MD
Signature of Recommending Physician

JEFFREY L. MOORE MD
Name of Recommending Physician
(Please print or type)

410 Wabash Ave, Akron Ohio 44307
Address of Recommending Physician
(Include City, State, Zip)

216-384-7670
Telephone Number
(Include Area Code)

(SEAL)

Ohio 53478
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 21st day of May, 1990.

Barbara Lohmier
Notary Public

BARBARA LOHMIER, Notary Public
Residence - Summit County
State Wide Jurisdiction, Ohio
My Commission Expires July 31, 1994

Date Commission Expires

Upon completion return to:

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

Nalini Ohlisundar DO.
Signature of Applicant

JUL 13

5/25/90
Date Photo Taken

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

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

Dear Sir:

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

This certifies that Nalini Obilisundar, D.O. (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[ ] intern
[ ] resident in _____ (Department)
[ ] clinical fellow

at Long Beach Memorial Hospital (Name of Hospital), 455 East Bay Drive, Long Beach, NY 11561 (Complete Address of Hospital)

from 7/1/88 beginning (month/day/year) to 6/30/89 ending (month/day/year). It is further certified that the above name

[X] was awarded a certificate on 6/30/89 (month/day/year)
[ ] was not

and that the training

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

John R Combes Jr

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

(SEAL OF HOSPITAL)

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

5/16/90
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

STATE MEDICAL BOARD OF OHIO
90 JUN -4 PM 3:57

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

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

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

Nalini Obilisundar D.O.
Signature of Applicant

Subscribed and sworn to before me this 12th day of July 1990.

Barbara Lohmier
Notary Public Signature

BARBARA LOHMIER, Notary Public
Residence - Summit County
State Wide Jurisdiction, Ohio
My Commission Expires July 31, 1994

(NOTARY SEAL)

Date Commission Expires

JUL 13

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO _____

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

Ray 2. Bumgarner
Entrance Examiner

Henry S. Crawford M.D.
Secretary

_____
Date Issued

FOR BOARD USE ONLY

NAME: Obilisundar, Malini

CERTIFICATE #: 5138 DATE ISSUED 9-7-90

FILED November 17, 19 89

FEE _____

DETERMINATION:

BOARD ACTION: 8/90PV

BASIS OF LICENSURE:

PRELIMINARY EDUCATION FORM

56-29

My name IN FULL is Obilisundar (LAST) Nalini (FIRST) --- (MIDDLE)

High School or Equivalent: Forest Hills High School (SCHOOL NAME) Forest Hills (CITY) New York (STATE) U.S.A (COUNTRY)

9/75 (FROM: MO/YR) 12/77 (TO: MO/YR) H.S. Regents Diploma (DEGREE)

Undergraduate College or Equivalent: S.U.N.Y. at Stonybrook (SCHOOL NAME) Long Island (CITY) New York (STATE) U.S.A. (COUNTRY)

1/78 (FROM: MO/YR) 6/80 (TO: MO/YR) Transferred (DEGREE)

C.U.N.Y.- Queens College (SCHOOL NAME) Flushing (CITY) New York (STATE) U.S.A (COUNTRY)

9/80 (FROM: MO/YR) 6/83 (TO: MO/YR) B.A. in Biology (DEGREE)

Medical School of Graduation: Ohio Univ. College of Osteopahic Medicine (SCHOOL NAME) Athens, Ohio (CITY) (STATE) U.S.A. (COUNTRY)

9/84 (FROM: MO/YR) 6/88 (TO: MO/YR) Doctor of Osteopathy (DEGREE)

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: 7720

DATE ISSUED: 8/21/90

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

Ray L. Bumgarner
Entrance Examiner

Nancy G. Crumbles M.D.
Secretary

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

Long Beach Memorial Hospital DATE *July 24, 1990*

Dear Doctor:

Dr. *Nalini Obilisundar* who is/was *Intern, transitional, 7/88-6/89* 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? *1 yr*

(2) What was/is your supervisory capacity? DIRECTOR OF MEDICAL EDUCATION

(3) At what hospital? LONG BEACH MEMORIAL HOSPITAL

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

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

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

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

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

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

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

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

April R Davidson
April Davidson
Licensure Assistant

John R Combes M.D.
Signature of Doctor, please type or print name legibly beneath

JOHN R COMBES, M.D.

DIRECTOR OF MEDICAL EDUCATION/MEDICAL DIRECTOR
Position

DATE: JULY 27, 1990

Telephone No. (516) 432-8000 (Include Area Code)

7/17

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

Akron General Medical Center

DATE July 24, 1990

Dear Doctor:

Dr. Nalini Obilisundar who is/was Resident, Psychiatry, 7/89-present is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 1 yr.

(2) What was/is your supervisory capacity? Program Director

(3) At what hospital? NEOUCOM / AGMC in Akron

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

(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) excellent

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

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

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

April R Davidson

April Davidson
Licensure Assistant

Jeffrey L. Moore, MD
Signature of Doctor, please type or print name legibly beneath

JEFFREY L. MOORE, MD

PROGRAM DIRECTOR, NEOUCOM PSYCH RESIDENCY
Position

DATE: 7-26-90

Telephone No. 216-384-7670 (Include Area Code)

National Board of Osteopathic Medical Examiners

2700 River Road, Suite 407, Des Plaines, Illinois 60018 (708) 635-9955

TRANSCRIPT

Part I passed	Scaled Score*1	Standard Score*2
Anatomy	79	
Physiology	77	
Biochemistry	83	
Pharmacology	82	
Pathology	83	
Microbiology	82	
Osteopathic Principles	83	
Scaled Score Average OR Minimum Total Passing Score 75/400	81.28	

Part II passed		
Surgery		483
Obstetrics & Gynecology		487
Psychiatry		550
Community Medicine & Medical Humanities*3		503
Pediatrics		472
Internal Medicine		429
Medical Jurisprudence*3		472
Osteopathic Principles		518
Scaled Score Average OR Minimum Total Passing Score 75/400		457

Part III passed	
General Test of Clinical Competence	452
Scaled Score Average OR Minimum Total Passing Score 75/350	

*1 Examinations taken prior to February 1987 are reported as scaled scores.
*2 Beginning in 1987 NBOME criteria for certification are based upon candidate's total score in Part I, Part II and Part III and not scores of individual subjects within each Part.
*3 Prior to March 1990, Part II included the areas of 'Preventive Medicine and Public Health' and 'Medical Jurisprudence'. Currently, those are combined in the area of 'Community Medicine and Medical Humanities'.

I, Joseph F. Smoley, Ph.D., Executive Director of the National Board of Osteopathic Medical Examiners, Inc., do hereby certify the above to be a true report of the record of

Nalini Obilisundar, D.O.

awarded Diplomate Certificate No. 16236 on July 1, 1989.

August 1, 1990
Date Prepared

Joseph F. Smoley, Ph.D.
Executive Director

National Board of Osteopathic Medical Examiners

hereby declares

Nalini Obilisundar, D.O.

having passed the examinations and furthermore having satisfied all eligibility requirements is awarded the status of

Diplomate

Of the National Board on this date July 1, 1989

Eugene Mochary Ph.D., D.O.
President

NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS · 1934 · N B O M E

John Fernandes, DO.
Secretary-Treasurer

16236
Certificate Number

The Board of Trustees of

The Ohio University

on the recommendation of the Faculty and in recognition of the completion of the prescribed course in the

College of Osteopathic Medicine

has conferred upon

Nalini Obilisundar

the degree of

Doctor of Osteopathy

with all the honors, rights, and privileges belonging thereto.
In witness whereof this diploma has been signed by the duly authorized officers of the University and the Board of Trustees and sealed with its corporate seal.

Given the one hundred eighty-fourth year of the University at Athens, Ohio on June eleventh, one thousand nine hundred eighty-eight.

Charles J. Ping
President of the University

Fritz J. Russ
Chairman of the Board of Trustees

Frank A. Logan M.D.
Dean of the College

Allen H. Seiger
Secretary of the Board

OHIO UNIVERSITAS OHIENSIS SIGILLUM PRIMUM MDCCCIV

OSTEOPATHIC MEDICINE • UNIVERSITY OHIO • COLLEGE OF

This is to certify that this is an exact duplicate copy of the original of this document as witnessed by me.

Dated: August 22, 1990

Barbara Lohmier
Notary Public

BARBARA LOHMIER, Notary Public
Residence - Summit County
State Wide Jurisdiction, Ohio
My Commission Expires July 31, 1994

New York College of Osteopathic Medicine

New York Institute of Technology

Be it known that the College and Affiliated Hospitals
attest to successful completion of its Clinical Education Program
by issuance of a certificate to

Nalini Obilisundar, D.O.

in the capacity of

Intern

at

Long Beach Memorial Hospital

In Witness Whereof we have hereunto affixed our signatures
and the seal of the College, this month of June, nineteen hundred and eighty-nine.

JUL 13

Matthew Achuro
President of New York Institute of Technology

Sheep F Fleisher D.O.
Dean and Provost for Medical Affairs

Hospital Administrator

John R Combes, M.D.
Director of Medical Education

Director of Medical Education

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 OSTEOPATHIC 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 Nalini O. Morris DO 3/21/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
34-00-5138	$250.00	05/01/96

NALINI OBILISUNDAR MORRIS,D.O.
203 13TH AVENUE NW
ROCHESTER MN 55901

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

P PSYCHIATRY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET: 1131 LINWOOD AVE SW
STREET:
CITY: NORTH CANTON STATE: OH ZIP CODE: 44720
COUNTY: STARK

⑆969696962⑆ 0934005138⑈ ⑈0000025000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
Street: 830 MILLER RD
Street: SUITE 303
City: FAIRLAWN State: OH Zip Code: 44333
County: SUMMIT

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)
Redacted

250.00 041096 AMOUNT BATCHDATE 934005138 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 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO OSTEOPATHIC 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 Nalini O. Morris DO 4/16/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
34-00-5138-M	$243.00	05/01/98

NALINI OBILISUNDAR MORRIS,D.O.
1131 LINWOOD AVENUE SW
NORTH CANTON OH 44720

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

P PSYCHIATRY

☒ 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: 0934005138 00000 24300

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)

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO OSTEOPATHIC 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 N Morris D.O. 3/15/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
34-00-5138-M	$305.00	04/01/2000

NALINI OBILISUNDAR MORRIS,D.O.
1131 LINWOOD AVENUE SW
NORTH CANTON OH 44720

I wish to apply for Emeritus status: ☐

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

P PSYCHIATRY

☒ 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: 0934005138 :0000030500:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
NALINI MORRIS M.D.
Street: 1131 LINWOOD AVE SW
Street:
City: NORTH CANTON State: OH Zip Code: 44720
County:

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

	YES	NO
1.) Been found guilty of, or pled guilty or no contest to, 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?	☐	☒

Redacted

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 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 OSTEOPATHIC 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
34-00-5138-M	$305.00	04/04/02	07/01/02

NALINI OBILISUNDAR MORRIS,D.O.
1131 LINWOOD AVENUE SW
NORTH CANTON OH 44720

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

P PSYCHIATRY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

STREET: 1131 LINWOOD AVE SW
STREET:
CITY: NORTH CANTON STATE: OH ZIP CODE: 44720
COUNTY: STARK

0934005138 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.

NOVA BEHAVIORAL HEALTH
Street
1207 N. STATE ST
Street
ALLIANCE OH 44601
City State Zip Code
STARK
County

REQUIRED: SOCIAL SECURITY NUMBER

Redacted

03282002 711700
1 9221 111
005138
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 OSTEOPATHIC 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] 3/29/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
34-00-5138-M	$305.00	04/01/04	07/01/04

NALINI OBILISUNDAR MORRIS,D.O.
1131 LINWOOD AVENUE SW
NORTH CANTON OH 44720

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

P PSYCHIATRY

☑ 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.

1131 LINWOOD AVE
STREET
STREET
NORTH CANTON OH 44720
CITY STATE ZIP CODE
STARK
COUNTY

0934005138 30500

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 ☒

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 or settlements 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 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 ☒

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.*

YORK BEHAVIORAL HEALTH
Street
1200 W. STATE ST
Street
ALLIANCE OH 44601
City State Zip Code
STARK
County

REQUIRED: [redacted] Redacted
SOCIAL SECURITY NUMBER

03312004 711700
2 0131 066
005138
1 SE 000030500

Date Posted: 6/6/2006 9:18:26 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	34.005138
License Name	NALINI MORRIS
Email Address	rmorris4@neo.rr.com

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   ..... PSYCHIATRY
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: 4/6/2008 9:09:32 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	Coleman Behavioral health 400 W.Tuscarawas St Ste 200 Canton, OH 44702 Stark County United States of America 330-438-2400 rmorris55@neo.rr.com
CREDENTIAL MAIL ADDRESS	Coleman Behavioral Health 400 W.Tuscarawas St Ste 200 Canton, OH 44702 Stark County 330-438-2400 rmorris55@neo.rr.com
MAIN	1131 LINWOOD AVENUE SW NORTH CANTON, OH 44720 Stark County (330)526-6825 rmorris55@neo.rr.com

License Information

License Number	34.005138
License Name	NALINI MORRIS
Email Address	rmorris4@neo.rr.com

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   ..... PSYCHIATRY
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: 6/25/2010 4:42:57 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	Phoenix Rising Behavioral Healthcare & Recovery 4974 Higbee Ave NW Ste 209 Canton, OH 44718 Stark County United States of America 330-493-4553 rmorris55@neo.rr.com
CREDENTIAL MAIL ADDRESS	1131 Linwood Ave SW North Canton, OH 44720 Stark County United States of America 330-526-6825 rmorris55@neo.rr.com

License Information

License Number	34.005138
License Name	NALINI MORRIS

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . PSYCHIATRY

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: 6/13/2012 5:53:58 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	34.005138
License Name	NALINI MORRIS

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

. . . . . PSYCHIATRY

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

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. . . . . YES

Discipline

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. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 40-44

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.

. 0

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

. 0

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

. 0

Clinical - Practice setting

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

. 40-44

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

. 0

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 44718

2. Enter the first county:

. . . . . Stark

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

. 2-5

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

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?

. . . . . NO

AOA Certified

1. Are you certified by an AOA Board?

. . . . . NO

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.