APP-SENT 9/14/90

STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

PLEASE TYPE OR PRINT CLEARLY

STATE MEDICAL BOARD OF OHIO
90 SEP 13 PM 3:08

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

NAME: Nunnally (LAST (Surname)) Lucy (FIRST) Ann (MIDDLE) (SUFFIX (Jr.,II))

ADDRESS: 4923 South Kimbark Avenue (STREET & NUMBER) Chicago (CITY) Illinois (STATE) 60615-2954 (ZIP) U.S.A. (COUNTRY)

TELEPHONE: BUSINESS: (312) 440-5170 (AREA CODE & NUMBER) HOME: (312) 548-3537 (AREA CODE & NUMBER)

BIRTH DATE: 11 / 12 / 53 (MO/DAY/YR) BIRTH PLACE: Norfolk, Virginia, U.S.A. (CITY, STATE, COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: The University of North Carolina at Chapel Hill (SCHOOL NAME) Chapel Hill, North Carolina 27612 (STREET ADDRESS, CITY, STATE, COUNTRY)

Aug / 25 / 1975 (FROM: MO/DAY/YR) May / 13 / 1979 (TO: MO/DAY/YR) M.D. (DEGREE RECEIVED) May / 13 / 1979 (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: The University of Chicago Hospitals and Clinics, 5841 S. Maryland Ave. Chicago, Ill. (NAME, STREET ADDRESS, CITY, STATE)
POSITION: Intern DEPARTMENT: Ob/Gyn DATE: June / 1979 (FROM: MO/YR) June / 1980 (TO: MO/YR)

HOSPITAL: The University of Chicago Hospitals and Clinics, Chicago, Illinois 60637 (NAME, STREET ADDRESS, CITY, STATE)
POSITION: Resident DEPARTMENT: Ob/Gyn DATE: July / 1980 (FROM: MO/YR) June / 1983 (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: __/__/__ LICENCE # _____ 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: Illinois ISSUE DATE: 08/15/1980 LICENSE #: 036-060801 CURRENT: YES X NO__

BASIS OF LICENSURE: Flex Exam/Endorsement

STATE: North Carolina ISSUE DATE: 08/22/1981 LICENSE #: 25517 CURRENT: YES X NO__

BASIS OF LICENSURE: Flex exam

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: North Carolina DATE TAKEN: June, 1979 PASS: X FAIL: ____ FULL (X) 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 X DATE __/__

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

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

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

A U.S. CITIZEN? YES X NO ____ BASIS OF CITIZENSHIP Born here DATE: 11/12/53

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, Lucy Ann Nunnally, M.D., 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.

Lucy Ann Nunnally MD September 7, 1990

SIGNATURE DATE

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

831

PRELIMINARY EDUCATION FORM

AW

STATE MEDICAL BOARD OF OHIO

90 SEP 13 PM 3:08

My name IN FULL is Nunnally (LAST) Lucy (FIRST) Ann (MIDDLE)

High School or Equivalent: J.O. Sanderson, H.S. (SCHOOL NAME) Raleigh, (CITY) North Carolina (STATE) U.S.A. (COUNTRY)

September / 1968 (FROM: MO/YR) June / 1971 (TO: MO/YR) High School Diploma (DEGREE)

Undergraduate College or Equivalent: Michigan State University, (SCHOOL NAME) East Lansing, (CITY) Michigan, (STATE) U.S.A. (COUNTRY)

September / 1971 (FROM: MO/YR) March / 1975 (TO: MO/YR) B.S. with Honors (DEGREE)

(SCHOOL NAME) (CITY) (STATE) (COUNTRY)

/ (FROM: MO/YR) / (TO: MO/YR) (DEGREE)

Medical School of Graduation: The University of North Carolina at Chapel Hill, (SCHOOL NAME) Chapel Hill, (CITY) North Carolina, (STATE) U.S.A (COUNTRY)

August / 1975 (FROM: MO/YR) May / 1979 (TO: MO/YR) M.D. (DEGREE)

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: 77956

DATE ISSUED: 1-28-91

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

Kay L. Bumgarner
Entrance Examiner

Henry G. Cramblett M.D.
Secretary

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): Nunnally (LAST (Surname)) Lucy (FIRST) Ann (MIDDLE) (SUFFIX (Jr., II))

3. NAME (As you prefer it inscribed on your Ohio license): Nunnally (LAST (Surname)) L. (FIRST) Ann (MIDDLE) (SUFFIX (Jr., II))

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

5. CURRENT ADDRESS: 4923 South Kimbark Avenue (STREET NUMBER & NAME)
Chicago (CITY) Illinois (STATE) 60615-2954 (ZIP CODE) U.S.A. (COUNTRY)

6. PHYSICAL DESCRIPTION: 5'2" (HEIGHT) 145# (WEIGHT) Blond (HAIR COLOR) Blue (COLOR OF EYES) None (IDENTIFYING MARKS)

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

8. CITY IN OHIO WHERE YOU PLAN TO PRACTICE: Canton (CITY) OR Stark (COUNTY)
PLANS OF PRACTICE: General Ob-Gyn

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

NAME OF SPECIALTY BOARD	BOARD CERTIFIED YES	BOARD CERTIFIED NO	YEAR CERTIFIED	COUNTRY
Ob-Gyn	[X]	[ ]	1985	U.S.A.
	[ ]	[ ]		
	[ ]	[ ]		

FOR OFFICE USE ONLY 34 35

1-5
1-31-90
1-14-91
165.00 pd 1048

STATE MEDICAL BOARD
91 JAN 10 PM 2:51

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

Lucy Ann Nunnally, M.D.

Application for Licensure in Ohio

Additional Information

Question #3:

In June, 1984 I resigned my professional association with Drs. Eisenberg and Camara voluntarily. This was a part time one year association which required an inordinately long commute for me so I resigned at the end of my contract year. This practice was affiliated with Northwest Community Hospital and I concurrently resigned my staff priveleges at Northwest community Hospital.

In August of 1987 I resigned my professional association with the Michael Reese Health Plan (HMO) in order to accept a position in the Women's Health Institute of Michael Reese Hospital.

L. Ann Nunnally MD

Lucy Ann Nunnally, M.D. Supplemental information.

Question #18:

To my knowledge no professional liability claims have been paid on my behalf, nor have I personally paid any such claims.

As of October 1990, the following five cases appeared on the computer files of the Cook County Circuit Court:

83L013223 Estate of V. Bland vs. University of Chicago Hospitals, et.al.
An infant was born on 11/80 and expired 7/81. The diagnosis was unclear.

The case was filed, never served, then dismissed by plaintiffs. My involvement in this case was as a second year resident.

86L10038 P. Sanford, formerly Hale, vs. Michael Reese Hospital, et.al.
The patient was treated at another facility in 3/84 and subsequently required a D&C, laparoscopy, laparotomy with cornual resection and salpingectomy in 5/84.

This case was closed without payment after being voluntarily dismissed. My involvement with this case was as an attending supervising the residents.

85L009965 S. Nixon, Minor, vs. Michael Reese Hospital, et.al.
Infant was born by vacuum extraction 2/23/84 and suffered a shoulder dystocia with subsequent Erb's Palsy of the left arm.

This case is ongoing. My involvement was as a member of Michael Reese HMO (a staff model HMO with seven Ob-Gyn physicians sharing call at Michael Reese Hospital.) I was present from 5:30 P.M. on 2/22/84 until 8:00 A.M. on 2/23/84 during which time labor was enhanced with pitocin. The mother progressed in labor over this time period and was 7 to 8 cm dilated when the attending for the day on 2/23/84 assumed responsibility for her care. The delivery occurred at 11:07 A.M. on 2/23/84.

89L13641 Estate of M. Rosenberg, deceased infant, vs. Michael Reese Hospital, et.al.
Infant was born 7/20/87 at 41 plus weeks of gestation by emergency c/section due to bradycardia in the second stage of labor. The infant suffered seizures beginning shortly after birth and expired 9/87.

This case is ongoing. This mother was the private patient of another attending at Michael Reese Hospital. My involvement was to provide a consultation (second opinion) regarding C/section vs. trial of forceps. When I evaluated the patient, the bradycardia had already ensued and I advised emergency C/section.

84L16657 C. Morgan, Minor, vs. Michael Reese Hospital, et.al.
Infant was born 2/4/84 at 1:27 A.M. at 38 weeks plus gestation by C/section due to persistant decelerations in labor. Mother was admitted in spontaneous labor at 10 P.M. 2/3/84 after rupture of membranes at 9 P.M. Labor progressed from 3cm dilated and 50% effaced at 10 P.M. to 7cm dilated and 100% effaced by 1 A.M. 2/4/84. Scalp pH was performed at 11:30 P.M. and was found to be 7.27. When the decelerations persisted, and delivery was not imminent, a C/section was ordered at 12:45 A.M. on 2/4/84. Inordinant delays by nursing and anesthesia staffs resulted in

[signature] MD

Lucy Ann Nunnally, M.D. Supplemental information continued.

Question #18

84L16657 Continued

an additional 40 minutes lapsing prior to delivery of the infant. The infant was born depressed and acidotic and suffered from neonatal seizures and group B streptoccal sepsis. She continues to survive with cerebral palsy.

This case is ongoing. My involvement with this case was as the attending on call for the Michael Reese HMO. I completely managed this case from admission in labor through delivery, although I was not her prenatal physician. This case is likely to be settled or come to trial in 1991.

L. A. Nunnally MD

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.

Nunnally

DATES IN CHRONOLOGICAL 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. 6 / 79 month year TO 7 / 83 month year	University of Chicago Hosp & Clin Hospital/University/Other 5841 S. Maryland Ave. Chicago, Illinois 60637 Street Address City/State Zip	Resident in Ob-Gyn	100%	
b. 7 / 83 month year TO current month year	Michael Reese Hospital & Med. Cntr. Hospital/University/Other Lake Shore Drive and 31st Street Chicago, Illinois 60616 Street Address City/State Zip	Attending in Ob-Gyn	100%	
c. 7 / 83 month year TO 7 / 84 month year	Northwest Community Hospital Hospital/University/Other 800 West Central Road Arlington Heights, Illinois 60005 Street Address City/State Zip	Attending in Ob-Gyn	100%	
d. 7 / 83 month year TO 8 / 87 month year	Michael Reese Health Plan (HMO) Hospital/University/Other 2545 S. King Drive Chicago, Illinois 60616 Street Address City/State Zip	Attending in Ob-Gyn	100%	
e. 7 / 83 month year TO 7 / 84 month year	M. Eisenberg, M.D. P. Camara, M.D. Hospital/University/Other 125 East Lake Cook Road Suite 110 Buffalo Greve, Illinois 60090 Street Address City/State Zip	Private Practice Ob-Gyn	90	

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. 8 / 87 (month / year) TO current (month / year)	Women's Health Institute Hospital/University/Other 900 North Michigan Ave. Annex Chicago, Illinois 60611 Street Address City/State Zip	Attending in Ob-Gyn	100%	
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

Nunnally

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]

Neurally

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, Anne B. Ward MD, a licensed and practicing physician in the state of
Name of Recommending Physician

Illinois affirm that Lucy Ann Nunnally, M.D., has been known
Name of Applicant

to me personally and professionally for 7 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/superior to most
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: extremely compatible to patients and their needs
Additional comments: I would have her as my partner if she weren't having to leave Illinois

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

Anne B Ward MD
Signature of Recommending Physician

Anne B. Ward MD
Name of Recommending Physician
(Please print or type)

30 N. Michigan #1422 Chicago IL 60602
Address of Recommending Physician
(Include City, State, Zip)

312 - 726 7272
Telephone Number
(Include Area Code)

IL 36-51492
State of Licensure and License Number
of Recommending Physician

(SEAL)

Subscribed and sworn to this 19 day of October, 1990.

Margaret Walton-Head
Notary Public

4-18-92
Date Commission Expires

PHOTO SEAL
OF OFFICIAL SEAL"
MARGARET WALTON-HEAD
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 4/18/92

L. Ann Nunnally MD
Signature of Applicant

10/16/90
Date Photo Taken

Upon completion return to:

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

FORM 1

AMS

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, Luis A. CIBILS, M.D., a licensed and practicing physician in the state of
Name of Recommending Physician
Illinois affirm that Lucy Ann Nunnally, M.D., has been known
Name of Applicant
to me personally and professionally for 10 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 (it is her native tongue)
I rate his/her ability to work well with peers and medical staff as: physician, attending
His/her relationship with patients is: excellent
Additional comments: Dr. Nunnally is one of the best Ob-Gyn trained at the Chicago Lying-in Hospital while I came here in 1966

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

Luis A. Cibils
Signature of Recommending Physician

Luis A. CIBILS, M.D.
Name of Recommending Physician
(Please print or type)

5841 S. Maryland Ave
Chicago, Illinois 60637
Address of Recommending Physician
(Include City, State, Zip)

312 - 702-6589
Telephone Number
(Include Area Code)

(SEAL)

Illinois 36-40629
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 8th day of November, 1990.

Evelyn Pope
Notary Public
My Commission Expires July 16, 1993
Date Commission Expires

L. Ann Nunnally MD
Signature of Applicant

10/16/90
Date Photo Taken

Upon completion return to:

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

STATE MEDICAL BOARD OF OHIO
90 NOV 13 AM 8:43

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 Lucy Ann Nunnally, M.D. (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[X] intern
[X] resident in Ob-Gyn (Department)
[ ] clinical fellow

at University of Chicago Hospitals and Clinics (Name of Hospital), 5841 S. Maryland, Chicago, Illinois 60637 (Complete Address of Hospital)

from June 26, 1979 (beginning month/day/year) to July 1, 1983 (ending month/day/year). It is further certified that the above name

[X] was awarded a certificate on June 30, 1983 (month/day/year)
[ ] was not

and that the training

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

(SEAL OF HOSPITAL)

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

Arthur L. Herbst, M.D.
Name (Please print or type)

October 22, 1990
Date

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

Upon completion return to:

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

FORM 3

CERTIFICATE OF STATE BOARD

TO ALL STATE BOARDS-DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED OCT 1990

This form must be completed for applicants who are applying for endorsement of another state license.

Acting on behalf of the Board of Medical Examiners of the State of North Carolina
Name of State Board

I do hereby certify that Dr. Lucy Ann Nunnally, M.D. License # 25517
Name of Licensee

was on the 22 day of August 19 81, granted a license to practice Medicine in the State of North Carolina based upon written examination of:

[X] FLEX Examination administered in this state

[ ] Examination administered in _____, but accepted as if taken in this state

[ ] Written examination prepared by this state

[ ] Other (Please specify)_____

***License current? Yes X No___ If not, please explain_____

I further certify that the aforesaid physician in ~~his~~/her written examination before this Board on June 12-14, 1979, obtained a general average of 79.9 or a FLEX Weighted Average of _____ in the following subjects:

SUBJECT	PERCENTAGE	SUBJECT	PERCENTAGE
Anatomy-70; Physiology-71; Biochemistr-68; Pathology-77; Microbiology-75; Behavioral Science - 75; Pharmacology-81	Basic Science Ave - 73.9		
Medicine - 80; Surgery-78; Obstetrics-89; Public Health-83; Pediatrics-80 Psychiatry-82.7	Clinical Science Ave. - 80.1		

or a Component I score of _____ on _____ and Component II score of _____ on _____
month/year month/year

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

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

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

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

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

Bryant D. Davis Jr.
Signature of Secretary, President or Executive Secretary, Original signatures only, name stamps will not be accepted.

Upon completion, return to:

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

10/19/90
Date

Illinois Department of Professional Regulation

Kevin K. Wright
Director

James R. Thompson
Governor

C E R T I F I C A T I O N

October 29, 1990

State Medical Board
77 South High Street, 17th Floor
Columbus, OH 43215

I, Kevin K. Wright, do hereby certify that I am the Director of the Department of Professional Regulation, a department of the government of the State of Illinois; that I am the keeper of the records of the Department of Professional Regulation and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	LUCY ANN NUNNALLY
WAS ISSUED LICENSE NO:	036-60801
ON:	08/26/80
TO PRACTICE AS A:	LICENSED PHYSICIAN & SURGEON
LICENSED BY:	FLEX ENDORSEMENT
CURRENT LICENSURE STATUS IS:	ACTIVE
CURRENT LICENSE EXPIRES:	07/31/93

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED.

The information above is the only certification information provided by this Department. If other information is needed, it must be obtained from the above-named individual or the agency or institution which initially generated the information. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Department.

For detailed information regarding the type and length of discipline, if any, submit a written request to the Regulatory Unit at the Department's Chicago office.

Kevin K. Wright
Director

S E A L

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800

State of Illinois Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/814-4500

FORM 4

VERIFICATION OF LICENSE

STATE MEDICAL BOARD

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

STATE OF ILLINOIS
OCT 16 1990
EXAMINING

TO BE COMPLETED BY APPLICANTS

Lucy Ann Nunnally, M.D.	036-060801	August, 1980
Name in Full	License Number	Issue Date

4923 South Kimbark Avenue
Complete Address (Include zip code)
Chicago, Illinois 60615-2954

November 12, 1953
Date of Birth

The University of North Carolina at Chapel Hill
Medical School Graduation

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

L. Ann Nunnally MD October 14, 1990
Signature of Applicant Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province _____ Name of Licensee _____

License Number _____ Date Issued _____

Is license current? _____

If not, please explain _____

What is the basis of the license?

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

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES _____ NO _____ CANNDT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

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If yes, please attach details.

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

(BOARD SEAL)

Signed: _____
Title: _____
Date: _____

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

[redacted]:

[redacted]

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 Illinois

COUNTY OF Cook

I, Lucy Ann Nunnally, M.D. 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.

L. Ann Nunnally MD
Signature of Applicant

Subscribed sworn to before me this 16th day of October 19 90.

"OFFICIAL SEAL"
VELMA L. BROWN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 5-13-93

(NOTARY SEAL)

Velma L Brown
Notary Public Signature

May 13, 1993
Date Commission Expires

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO _____

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

_____
Entrance Examiner

_____
Secretary

_____
Date Issued

FOR BOARD USE ONLY

NAME: [illegible] Lucy A

CERTIFICATE #: _____ DATE ISSUED _____

FILED September 14, 19 90

FEE _____

DETERMINATION:

BOARD ACTION:

BASIS OF LICENSURE:

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 02/19/

NAME: NUNNALLY, L ANN
SCHOOL: UN OF N CAROLINA SM, CHAPEL HILL NC
DEGREE CONFERRED: MD
DATE CONFERRED: 05/13/79

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CITY: ST:
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RESIDENCY

HOSPITAL: U OF CHICAGO
CITY: CHICAGO ST: IL
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NAME: LUIS CIBILS, MD CITY: CHICAGO STATE: IL

SPECIALITY
CODE: OBSTETRICS & GYNECOLOGY
CODE:
CODE:

SPECIALITY
BOARD: 1985

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:	X		
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD			
JUDITH S. DANIELS, MD			
THOMAS E. GRETTER, MD	✓		
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Nunnally

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91 FEB 25 AM 11:28
STATE MEDICAL BOARD

91 JAN 10 PM 2:51
STATE MEDICAL BOARD

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AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 02/19/

NAME: NUNNALLY, L ANN
SCHOOL: UN OF N CAROLINA SM, CHAPEL HILL NC
DEGREE CONFERRED: MD
DATE CONFERRED: 05/13/79

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

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CITY: CHICAGO ST: IL
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FLEX EXAM

DATE OF EXAM: 06/79 STATE EXAM WAS TAKEN: NC

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CC: 80.1% FWA: 79.9%
BASIS: FLEX

NEW FLEX

COMPONENT_I: %
COMPONENT_II: %
BASIS_ST: NC

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NAME: ANN B WARD, MD CITY: CHICAGO STATE: IL
NAME: LUIS CIBILS, MD CITY: CHICAGO STATE: IL

SPECIALITY CODE: OBSTETRICS & GYNECOLOGY
SPECIALITY BOARD: 1985
CODE:
CODE:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:	X		
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD			
JUDITH S. DANIELS, MD			
THOMAS E. GRETTER, MD			
THERESA M. HOM, DO			
TIMOTHY JOST	✓		
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
CAROL ROLFES			
JOHNATHAN S. ROSS,MD			
TIMOTHY L. STEPHENS, JR., MD			

STATE MEDICAL BOARD
81 FEB 25 AM 8:26

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THOMAS E. GRETTER, MD			
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TIMOTHY JOST		MAR.01 1991	
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A.W.

AFFIDAVIT AND RELEASE

STATE MEDICAL BOARD OF OHIO
91 FEB 1 2

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 ILLINOIS

COUNTY OF COOK

I, L. ANN NUNNALLY MD 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.

X L. Ann Nunnally MD
Signature of Applicant

Subscribed sworn to before me this 12th day of February 19 91.

X Sergenet L Walton-Head
Notary Public Signature

(NOTARY SEAL)

X 4-18-92
Date Commission Expires

" OFFICIAL SEAL "
SERGENET WALTON-HEAD
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 4/18/92

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO _____

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

Ray L. Bumgarner
Entrance Examiner

Henry S. Cramblett M.D.
Secretary

_____
Date Issued

FOR BOARD USE ONLY

NAME: Nunnally, Lucy Ann

CERTIFICATE #: 61531 DATE ISSUED 4-30-91

FILED 9-14 _____, 19 90

FEE _____

DETERMINATION:

BOARD ACTION: 2/91PV

BASIS OF LICENSURE:

THE WOMEN'S HEALTH INSTITUTE

April 18, 1991

State Medical Board Of Ohio
77 S. High Street
17th Floor
Columbus, OH 43266-0315

Re: L. Ann Nunnally, M.D.
SS# Redacted

To Whom It May Concern:

This is to certify that L. Ann Nunnally, M.D. has been and is currently employed by Women's Health Institute/Michael Reese North from August, 1987 to the present time. This facility is owned by Michael Reese Hospital and Medical Center (now Humana Michael Reese). Dr. Nunnally has served as one of our general OB-GYN physicians since the inception of this program.

Sincerely,

M. Joan Stukel

M. Joan Stukel
Director of Operations
Vice President of Off-Campus Ventures

312.440.5170

STATE MEDICAL BOARD
91 APR 23 PM 1:58

Michael Reese
North Michigan Avenue
60 East Delaware Place
Chicago, Illinois 60611

Dedicated as the Nathan Cummings Outpatient Center, a multi-specialty, private practice health care facility.

Michael Reese Medical Center

RECEIVED
JAN 29 1991

STATE MEDICAL BOARD OF OHIO

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

DATE January 22, 1991

Dear Doctor:

[redacted] 7-83- Current

Dr. Lucy Ann Nunnally, MD who is/was Attending OB/GYN- is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. **This form must be completed and returned to our office within thirty (30) days to ensure processing of the doctor's application.** Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 10 YRS

(2) What is/was your supervisory capacity? (1) COLLEAGUE, CHIEF OF DEPT 8MB

(3) At what hospital? MICHAEL REESE

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

(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)

STATE MEDICAL BOARD OF OHIO 91 FEB 15 AM 8:19

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

April R Woody
April Woody
Licensure Assistant

Allan G Charles MD
Signature of Doctor, please type or print name legibly beneath

ALLAN G. CHARLES

CHIEF OB/GYN
Position

Telephone No. (312) 791-4003 (Include Area Code)

RECEIVED
FEB 6 1991
DEPARTMENT OF OBSTETRICS/GYNECOLOGY

GOJO 23-S

The Federation of State Medical Boards

of the United States

INCORPORATED

6000 WESTERN PLACE, SUITE 707
FORT WORTH, TEXAS 76107-4618
(817) 735-8445

To: Ohio State Medical Board.

Subject: FLEX/SPEX Scores

LUCY ANN NUNNALLY
4923 SOUTH KIMBACK AVE
CHICAGO, IL
60615

It is certified that the named physician took the Federation Licensing and/or Special Purpose Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: 531112004 **Date of Certification:** 11/09/90

EXAMINATION DATE: 06/79
FOR INSTITUTION: 134

-NC

BASIC SCIENCE

Anatomy:	70.00
Physiology:	71.00
Biochemistry:	68.00
Pathology:	77.00
Microbiology:	75.00
Pharmacology:	81.00
Behavioral Science:	75.00
BASIC SCIENCE AVE.:	73.90

CLINICAL SCIENCE

Medicine:	80.00
Surgery:	78.00
Obstetrics:	89.00
Public Health:	83.00
Pediatrics:	80.00
Psychiatry:	86.00
CLINICAL SCIENCE AVG.:	82.70
CLINICAL COMPETENCE AVG.:	80.10
FLEX WEIGHTED AVG.:	79.90

STATE MEDICAL BOARD OF OHIO
90 NOV 14 AM 8:15

* *

Furthermore: A search of the Federation's Board Action Data Bank reveals no reported disciplinary information on the above named physician.

The University of North Carolina at Chapel Hill

To all to whom these presents shall come

Greeting

Be it known that

Lucy Ann Nunnally

having completed the studies and fulfilled the requirements of the Faculty for the degree of

Doctor of Medicine

has accordingly been admitted to that degree, with all the rights, honors, and privileges thereunto appertaining.

In witness whereof, the Seal of the University and the signatures of duly authorized officers are affixed to this diploma.

Given at Chapel Hill, in the State of North Carolina, this thirteenth day of May in the year of Our Lord nineteen hundred and seventy-nine and of this University the one hundred and ninetieth.

W A Johnson

Chairman of the Board of Governors
The University of North Carolina

W Friday

President
The University of North Carolina

Thomas W. Lambeth

Chairman of the Board of Trustees
The University of North Carolina at Chapel Hill

N. Fordree Taylor

Chancellor
The University of North Carolina at Chapel Hill

Robert Tyler L. Fordham, III

Dean

updated 10.1.91 sc

I HEREBY CERTIFY THAT I HAVE RECEIVED MY WALL CERTIFICATE

NUMBER 61531, ON 7/?/91
(Date)

L. ANN NUNNALLY
Name

5205 FOXCHASE AVENUE N.W.
CANTON, OHIO 44718

City State/County Zip

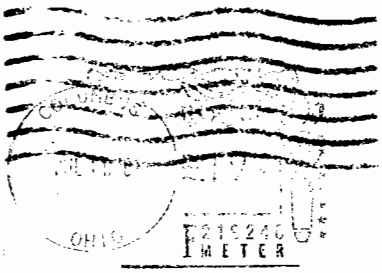
L. A. Nunnally MD
Signature

PLEASE CHECK IF THIS IS A CHANGE OF ADDRESS X

MED 1013 (4/89)

L. ANN [redacted] M.D.
5205 FOXCHASE AVE., N.W.
CANTON, OHIO 44718

CANTON. OH 447
PM
2 AUG
199



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

91 AUG 26 PM 1:17

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] MD 6/29/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-1531	$160.00	07/01/92

L ANN NUNNALLY,M.D.
5205 FOXCHASE AVE NW
CANTON OH 44718

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

PROCESSED

[X] 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

⑆96969696 2⑆ 0935061531⑈ ⑈0000016000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
Street: 2603 CLEVELAND AVE NW
Street:
City: CANTON State: OH Zip Code: 44709
County: STARK

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

A.) A felony or misdemeanor. YES [ ] NO [X]

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

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 [X]

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

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 [X]

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

SOCIAL SECURITY NUMBER (Optional for purposes of identification) [redacted]

883 00232 070692 00705 MC 160.00 0702 92
TAX BATCH DATE SEQ MC AMOUNT BATCHDATE

935061531
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 L. A. N. MD 5/1/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-1531	$250.00	05/01/94

L ANN NUNNALLY,M.D.
5205 FOXCHASE AVE NW
CANTON OH 44718

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☒ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935061531 :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:

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

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 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 L. A. Nunnally MD 5/13/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-1531	$250.00	05/01/96

L ANN NUNNALLY,M.D.
5205 FOXCHASE AVE NW
CANTON OH 44718

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: 0935061531 00000250000

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
Street 5205 WHITE POND DR STE B
City AKRON State OH Zip Code 44320
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 ☒

AMOUNT PAID/DATE
935061531
ACCOUNT #

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X L. A. Nunnally MD 3/30/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-1531-N	$211.00	05/01/98

L ANN NUNNALLY,M.D.
5205 FOXCHASE AVE NW
CANTON OH 44718

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☒ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935061531 :00000 21100:

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

Street 6014 E MARKET ST
Street AKRON OH 44304
City State Zip Code
County

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

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

SOCIAL SECURITY NUMBER (Optional for purposes of identification)

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X L. Ann Nunnally MD 12/24/99
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-1531-N	$305.00	01/01/00

L ANN NUNNALLY,M.D.
~~5205 FOXCHASE AVE NW~~
~~CANTON OH 44718~~

I wish to apply for Emeritus status: ☐

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

1436 RESERVE DR
STREET
STREET
AKRON OH 44333
CITY STATE ZIP CODE
SUMMIT
COUNTY

:969696962: 0935061531 :0000030500:

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

Street
Street
City State Zip Code
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?*

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.) *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?*

YES ☐ NO ☒ 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?*

YES ☐ NO ☒ 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 1999-2001 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 L. Ann Nunnally MD 1/14/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-1531-N	$305.00	01/01/02	04/01/02

L ANN NUNNALLY,M.D.
1436 RESERVE DR
AKRON OH 44333

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

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

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

1436 RESERVE DR
STREET
STREET
AKRON OH 44333
CITY STATE ZIP CODE
SUMMIT
COUNTY

0935061531 30500

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

	YES	NO
1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?	☐	☒
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.	☐	☒
3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?	☐	☒
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?	☐	☒
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.	☐	☒
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?**	☐	☒

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

Street
Street
City State Zip Code
County

SOCIAL SECURITY NUMBER Redacted

01242002 111700
0013 007
061531
SE 0000038500

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 2002 - 2004 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 L. A- Nunnally MD 12/29/03
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-1531-N	$305.00	01/01/04	04/01/04

L ANN NUNNALLY,M.D.
1436 RESERVE DR
AKRON OH 44333

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

X SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.
1436 RESERVE DR
STREET
STREET
AKRON OH 44333
CITY STATE ZIP CODE
SUMMIT
COUNTY

0935061531 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 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 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 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.

Street
Street
City State Zip Code
County

REQUIRED: SOCIAL SECURITY NUMBER Redacted

Date Posted: 11/21/2005 12:35:42 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	35.061531
License Name	L NUNNALLY
Email Address	

Fees

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

Specialty Codes

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

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:

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	35.061531
License Name	L NUNNALLY
Email Address	iraray@bigplanet.com

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

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

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . 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: 3/30/2008 11:22:46 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	35.061531
License Name	L NUNNALLY
Email Address	iraray@bigplanet.com

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

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

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

. . . . . NO

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. . . . . NO

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. . . . . Mary E. Schatzman, NP

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Date Posted: 3/8/2010 11:43:02 AM

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

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License Name	L NUNNALLY

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Total Fees	**$305.00**

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   ..... *{not Answered}*
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Social Security Number

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Date Posted: 3/13/2012 11:05:41 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	692 E Market St Akron, OH 44304 Summit County United States of America 330 535-9191 LANN1112@yahoo.com
CREDENTIAL MAIL ADDRESS	4681 Wendrick Dr West Bloomfield, MI 48323 United States of America 330 573-2003 lann1112@yahoo.com
MAIN	4681 Wendrick Dr West Boomfield, MI 48323 United States of America 330 573-2003 lann1112@yahoo.com

License Information

License Number	35.061531
License Name	L NUNNALLY

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

. . . . . GYNECOLOGY

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

. . . . . GYNECOLOGY

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

. . . . . GYNECOLOGY

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. . . . . NO

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. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 15-19

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

. 0

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

issues, etc.)

. 1-4

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

. 1-4

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).

. 15-19

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:

. 44304

2. Enter the first county:

. . . . . Summit

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . Cuyahoga

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

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)

. . . . . 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?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

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licensure may be grounds for disciplinary action against my license.

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