APPLICATION FOR ENDORSEMENT OF A MEDICAL LICENSE

BY

The State Medical Board, State of Ohio

FORM 1.

I hereby make application for a license to practice Medicine and Surgery in the State of Ohio, and submit the following statement regarding my preliminary education.

1. Name Erlinda E. Uy Chand
2. Place of birth Batangas, Philippines
3. Address 762 Eastland Avenue, Akron, Ohio 44305
   Date of birth March 9, 1939
4. Intended residence Akron, Ohio

5. PRELIMINARY EDUCATION.

Name and Location of Institution Attended and Degree Received.	Period and Date of Study.	
St. Scholastica's College, H.S. Manila P.I.	4 years	1952 to 1956
University of Sto. Tomas, P.I. Premed	2 years	1956 to 1958

Received Ohio Certificate of Preliminary Education No. 42353; issued by ....., 9/14/70 (Date)

6. I have made application to the following State Examining and Licensing Boards, and no others (Give names of States and dates of application—Reciprocity or Examination.) Pennsylvania May 1970, Indiana June 1970 Both by Examinations

and received a certificate from each except as follows: (Give names of States and dates of application — Reciprocity or Examination.)

7. MEDICAL EDUCATION.

Give the date and source of each medical credential, diploma, license or degree which you hold. Medical Diploma March 1963 - University of Sto. Tomas, Philippines Medical License Nov. 1963

Attended 4 full courses of medical lectures as follows, to-wit:

1st Course at University of Sto. Tomas from 1958 June to 1959 march
2nd Course at University of Sto Tomas from 1959 June to 1960 march
3rd Course at University of Sto. Tomas from 1960 June to 1961 march
4th Course at University of Sto Tomas from 1961 June to 1962 march 1962-63 - Internship

Was granted a diploma by University of Sto. Tomas College of Medicine (Name of Medical College.) located at Manila State of Republic Philippines on the ..... day of ....., 19....

8. Time of practice AKRON, Ohio, will begin practice as soon as reciprocity is granted. (Give places and dates)

9. Has any license entitling you to practice in any foreign country or in any state or territory of the United States been suspended or revoked? NO (Answer Yes or No)

If so, specify: (State or Country) (Charge) (Date)

Have you ever been or are you now addicted to narcotic drugs? NO (Yes or No)

Have you ever been charged with addiction? NO (Yes or No)

Specify charge:

Have you ever found it necessary to surrender your narcotic license? NO (Yes or No)

Have you ever been charged with a violation of a Federal Law, State Law or a municipal ordinance other than a traffic violation? NO (Yes or No)

If so, give full particulars: (Offense) (Place) (Disposition)

(Date of Disposition)

10. PHYSICAL DESCRIPTION OF APPLICANT.

Race BROWN Native of Philippines Complexion light Brown

Color of hair DARK BROWN Color of eyes BROWN Height 5'2"

Medium Weight 110 lbs Marks mole at left cheek

(Cross out words not answering description.)

FORM II. *AFFIDAVIT.

STATE OF Ohio
COUNTY OF Summit } ss:

On this 9th day of Sept. 19 70, personally appeared before me, ERLINDA UY CHAND within and for the County and State aforesaid, ERLINDA UY CHAND who being duly sworn says that he is the person referred to in the foregoing application for license to practice medicine in the State of Ohio; that the statements therein are strictly true in every respect, and that SHE has read and understands this Affidavit.

Erlinda Uy Chand M.D.
(Signature of Applicant.)

Signed and sworn to before me, this 9th day of September, 19 70

(Seal.) Carl E. Meador
(Official designation of officer administering oath.)

* Must be sworn to before an officer authorized to administer oaths, or a Federal officer.

CARL E. MEADOR, Notary Public
Attorney At Law - State Of Ohio
My Commission Has No Expiration Data,

FORM III.

CERTIFIED COPY OF STATE LICENSE OR CERTIFICATE.

(A verbatim copy to follow here, over Seal of State Licensing Board, certified to by the Secretary thereof.)

I hereby certify that the above is a verbatim copy of license No. 31124, issued to Dr. Erlinda E. Uy Chand by the Pa. St. Bd. of Med. Ed. & Lic. on the 25th day of June, 1970

(Seal.) John G. Cochlay, M.D.
Secretary.

FORM IV.

CERTIFICATE AND RECOMMENDATION OF SECRETARY.

Acting in behalf of the Penna. State Board of Medical Education & Licensure
(Name of State Board.)

I do hereby certify that Dr. Erlinda E. Uy Chand was on the 25th day of June, 19 70, granted a license to practice Medicine and Surgery in the State of Pennsylvania on the basis of written examination
(State board examination or medical diploma of graduation.)

in the following subjects Public Health, Sanitation & Medical Jurisprudence, 80; Surgery, 84; Pathology, 81; Anatomy & Bacteriology, 78; Obstetrics, Gynecology & Pediatrics, 80; Chemistry, Physiology & Pharmacology, 81; Symptomatology & Therapeutics, 77.

on which ~~s~~he received an average of 80.3 per cent, and from evidence on file in this office, I do hereby certify to the good moral and professional standing of Dr. Erlinda E. Uy Chand of Akron, State of Ohio, and recommend Her to The State Medical Board of Ohio, as a proper person for medical licensure.

The applicant must satisfy the Board of Medical Education & Licensure on the question of standing and moral character before seal of said Board is affixed.

(Seal.) John G. Cochlay, M.D.
Secretary.

September 15, 1970
(Date)

FORM V.

AFFIDAVIT OF PHYSICIANS.

STATE OF OHIO
SUMMIT COUNTY } ss:

Before me, personally appeared Geo. D. Solomon Jr M. D.

known to me as a reputable practicing physician and surgeon, of good moral character, and on being sworn says that he has known ERLINDA CHAND M. D., well for 5 years and knows Her to be of good moral and professional character, that She is a graduate of Univ. of Santo Tomas College in the year 1963, that She has been in the practice of Medicine for the last twelve months at Cuy. Falls O, and recommended Her as worthy of professional recognition and that the foregoing physical description is correct.

Address 625 Portage Tr Geo D Solomon Jr M. D.
Cuyahoga Falls Ohio, Graduate of St Louis Univ, Certificate No. 173 (019401)

Subscribed and sworn to this 9th day of Sept, 19 70

(Seal.) Ronald R. Saal Notary Public
RONALD R. SAAL, Notary Public
My Commission Expires May 1, 1971 Notary Public.

STATE OF Ohio
Summit COUNTY } ss:

Before me, personally appeared Carl J. Paternite M. D.

known to me as a reputable practicing physician and surgeon, of good moral character, and on being sworn says that he has known Erlinda Uy Chamd M. D., well for 5 years and knows her to be of good moral and professional character, that She is a graduate of University of Sto. Tomas College in the year 1963, that She has been in the practice of Medicine for the last twelve months at Cuyahoga Falls and Akron, and recommended her as worthy of professional recognition and that the foregoing physical description is correct.

Address 1815 W. Market St Carl J. Paternite M. D.
Akron O, Graduate of U of Cincinnati, Certificate No. 13095

Subscribed and sworn to this 9th day of Sept, 19 70

(Seal.) Ronald R. Saal Notary Public
RONALD R. SAAL, Notary Public
My Commission Expires May 1, 1971 Notary Public.

FORM VI.

CERTIFICATE OF ETHICAL AND MORAL CHARACTER FROM PRESIDENT OR SECRETARY OF COUNTY, DISTRICT OR STATE MEDICAL SOCIETY:

P. O. Address ..... Date ....., 19 ..

I certify that Dr. ....., of .....,

is a member in good standing of the .....
and that he is an ethical practitioner of good moral character.

..... M. D.
President or Secretary.

I am not yet a member of the Summit County medical Society The society requires the possession of Ohio State license before admitting me to the membership. All my credentials had been submitted to the Secretary of the medical Society.

SECTION 4731.29. GENERAL CODE OF OHIO.

When a physician or surgeon licensed by the licensing department of another state, a territory or the District of Columbia or a diplomate of the National Board of Medical Examiners wishes to remove to this state to practice his profession, the State Medical Board may, in its discretion, issue to him a certificate to practice medicine and surgery in Ohio without requiring the applicant to submit to examination, provided he meets the requirements for entrance as set forth in Section 4731.09 and Section 4731.12. The fee for registration in this manner shall be one hundred dollars. Application shall be made on a form prescribed by the board.

Univ. of Santo Tomas
Philippines
1963

Penn. 1970

FOR USE OF SECRETARY ONLY.

State Certificate No. 33759

Issued 9/2/70

Application for Endorsement of a Medical License by State Medical Board, State of Ohio

CHAND, Erlinda E. Uy, M. D.

2-1 Castine Check

Filed 7-17-70

Fee $100.00 100.-

Presented to Board

Approved
Rejected
Withdrawn

Amt ok

9/2/70
(Appr. by Bd. [redacted])

QUALIFICATION

A certificate of registration showing that an examination has been made by the proper board of any state in which an average grade of not less than 75 per cent was awarded, the holder thereof having been at the time of said examination the legal possessor of a diploma from a medical college in good standing in the state where reciprocal registration is sought, may be accepted, in lieu of examination, as evidence of qualification. Provided, that in case the scope of the said examination was less than that prescribed by the state in which registration is sought, the applicant may be required to submit to a supplemental examination by the board thereof in such subjects as have not yet been covered.

INSTRUCTIONS.

1. The State Medical Board of Ohio holds regular meetings on the first Tuesday of January, April, July and October at Columbus.

2. Fill out Form I and make the necessary affidavit to Form II. Then obtain the affidavit required by Form V. This must be signed by two reputable physicians, residing in the applicant's home state or Ohio; then obtain certification of Form VI.

3. Forward to the Secretary of the Medical Board of the State in which the applicant is licensed, or the National Board of Medical Examiners, if a Diplomate. They will fill out Form III and IV, if justified in doing so, and return the blank to applicant.

4. The application should then be forwarded to the Secretary of the State Medical Board of Ohio.

5. Address all communications to the Secretary of The State Medical Board, Wyandotte Building, Columbus, Ohio 43215.

6. Applicants must be 21 years of age and citizens of the United States.

BIOGRAPHICAL DATA ON PHYSICIANS

from the Biographical - Historical files of
American Medical Association
535 N. Dearborn St.
Chicago, Illinois 60610

RECEIVED
SEP 14 1970
DEPARTMENT OF INVESTIGATION

This form is provided for your convenience in making routine inquiries regarding physicians seeking medical licensure in your state, hospital staff privileges or faculty positions. Please entet on this form data you wish verified and mail to the Member Services Unit of the AMA.

Full name of M.D. ~~CHANG,~~ Erlinda E. Uy ✓

Place of birth _____ Date of birth 1939

Professional Mailing Address 762 Eastland Ave., Akron, Ohio 44305

Medical Education: ✓

School Name Univ. of Santo Thomas, Philippines M.D. Degree 1963 (Year)

Internships:

Hospital	Location	Dates
		to
		to

Residencies and Fellowships:

Hospital	Location	Dates
		to
		to

M.D. Licensed to Practice Medicine in the Following States:

State * Penn. Year 1970; State _____ Year _____; State _____ Year _____

Inquiry Submitted by Ohio State Medical Board Title _____
(Your Name Here)

21 W. Broad St. City-State Columbus, Ohio 43215
(Affiliation - Licensing Board, Hospital or Medical School)

AMA Department of Investigation

MEMBER OF AMA

..... YES
..... NO

☒ Our records do not reveal any derogatory information.
☐ See attached memo for comments regarding applicant.

A check mark (✓) indicates that the data given corresponds to that listed in the AMA Master File of Physicians. Any discrepancies are as noted.

Date 9-17-70

Joan Alvarez
Joan Alvarez,
Member Services Unit

* not reported to date

SUMMARY OF CREDENTIALS SUBMITTED
(MUST BE TYPEWRITTEN)

Bd. Appr 9/2/70

NAME Erlinda E. Uy Chand

ADDRESS 762 Eastland Avenue, Akron, Ohio 44305

CITIZENSHIP _____ (Number) _____ (Date Issued) _____ (Location of Court)

DECLARATION OF INTENTION 31991 (Number) July 31, 1969 (Date Issued) Summit County Akron Ohio (Location of Court) trig

MEDICAL SCHOOL University of St. Tomas, Manila, P.I. (Name) (Location) March 28, 1963 (Graduation Date) trig

INTERNSHIP IN THE UNITED STATES OR CANADA

(NO CERTIFICATE)
Samaritan Hospital Troy, New York (Name of Hospital) (Location) January 1964 to Dec. 1964 (Dates of Service)

RESIDENCIES IN THE UNITED STATES OR CANADA (List Fellowships last, if applicable)

(NO CERTIFICATE)
Good Samaritan Hospital Cincinnati, Ohio (Name of Hospital) (Location) Jan. 1965 to Dec. 1965 (Dates of Service)

OK St. Thomas Hospital Akron, Ohio Jan. 1966 to July 1969

E.C.F.M.G. 45271 (Number) Manila, P.I. (Testing Location) Oct. 1963 (Year of Certification)

STATE IN WHICH LICENSED Pennsylvania State, 1970 (Name) (Year of Licensure) MD 031124 (Number, if any)

PLANS OF PRACTICE IN OHIO Private practice in Obstetrics &Gynecology

SUMMARY OF PROFESSIONAL ACTIVITIES ~~SINCE MEDICAL~~ SCHOOL GRADUATION (Account for each year since graduation):

1. January 1964 to Dec 1964..... Rotating Internship Samaritan Hospital Troy, New York

2. January 1965 to Dec. 1965...First year Radiology Residency at Good Samaritan Hospital Cincinnati, Ohio

3. Jan. 1966 to July 1969.....Completed Residency in Obstetrics&Gynecology St. Thomas Hospital Akron, OHIO

CHAND, ERLINDA E. - UY

✓ App. 9/3/70 ✓ Ann. 9/8/70 SD

(5 letters of recommendation)

✓ Ltr for Bd Sept 8/12/70 SD

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
COMMISSIONER OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
HARRISBURG

COMMISSIONER
JOHN P. JUDGE

DEPUTY COMMISSIONER
THEODORE F. FREED

LICENSING BOARDS

ARCHITECTS
BARBERS
CERTIFIED PUBLIC ACCOUNTANTS
CHIROPRACTIC
COSMETOLOGY
DENTAL
ENGINEERS
FUNERAL DIRECTORS
LANDSCAPE ARCHITECTS
MEDICAL
MOTOR VEHICLE SALESMEN
NURSES
OPTOMETRICAL
OSTEOPATHIC
PHARMACY
PODIATRY
REAL ESTATE
VETERINARY

September 15, 1970

TO WHOM IT MAY CONCERN:

The attached certification in connection with the application of Erlinda E. Uy Chand, M. D. was made in accordance with and subject to the Act of 1963, August 14, P.L. 957, amending the Act of June 3, 1911, P.L. 639, known as the Medical Practice Act.

The applicable provisions of the Section are hereby set forth as follows:

". . . Applicants from countries foreign to the territory of the United States, who desire to be licensed by said board, shall, before examination, also furnish proof as to age, moral character, use of alcohol, narcotics and other habit-forming drugs; shall present a certificate of United States citizenship or a declaration of intention, and shall present a certificate or diploma indicating the completion of a preliminary and medical and surgical education equivalent to the above. The license of any licensee who fulfils the requirements of this act relating to citizenship by presenting a declaration of intention of becoming a citizen, shall be automatically revoked by the board if such licensee does not present a certificate of United States citizenship to the board within seven years after original licensure. Each application to the said board, for examination or licensure, shall have attached thereto the affidavit or affirmation of the applicant as to its verity. Any applicant who knowlingly or wilfully makes a false statement of fact in his application shall be subject to prosecution for perjury."

Secretary, State Board of Medical
Education and Licensure

Copy of Record of Medical License

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF STATE

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETING:

WHEREAS, It appears by the report of the

STATE BOARD OF MEDICAL EDUCATION AND LICENSURE

of the Commonwealth of Pennsylvania that

.....Erlinda E. Ily Chand.....

having given satisfactory evidence of fitness as to age, character, preliminary education, medical instruction and all other matters required by law, was fully examined by the members of the State Board of Medical Education and Licensure whose signatures are hereto attached, and found duly qualified for the practice of medicine and surgery, ...she..... is hereby, in accordance with the provisions of the Act of the General Assembly approved June 3, A. D. 1911, and amendments thereto, granted this LICENSE TO PRACTICE MEDICINE AND SURGERY in the Commonwealth of Pennsylvania.

IN WITNESS WHEREOF, We have hereunto set our hands and caused the Seal of the Commissioner of Professional and Occupational Affairs to be affixed at Harrisburg the ...25th day of ...JUNE....., 1970...

(s) Charles B. Hollis, M. D. ..... Chairman

Alva R. Cockley ..... Secretary

E. R. Brownellor, M. D. .....

John F. Hartman, M. D. .....

John W. Robertson, Jr., M.D. .....

William B. West, M. D. .....

.....

No. ..31124..... Enrolled in Medical License Record Book Volume ..... Page ...31124.....

I hereby certify that the above is a correct transcript from the State Medical Record Book, Vol. ....., Page ...31124....., of the State Board of Medical Education and Licensure filed with the Commissioner of Professional and Occupational Affairs.

(SEAL) .....John P. Judge.....

Commissioner

Please sign the receipt below and return at once to: Secretary of the State Medical Board
21 W. Broad Street
Columbus, Ohio 43215

AKRON O., October 15 19 70

Received of The State Medical Board, Certificate No. 32759
bearing my name Erlinda E. Uy Chand

P. O. Address 762 Eastland Avenue
AKRON, 44305 *, Ohio*
ZIP:

Chand, Erlina E.

32729

Issued 9/2/70

Endorsement

STATE OF OHIO
THE STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS OH 43215

August 2, 1989

Erlinda E. Uy Chand, M.D.
208 Grayling Dr., West
Akron, OH 44313

Dear Doctor:

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

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

As you are aware, the renewal period is every two years (1989-1990). It will be necessary to earn 100 credits with 40 being in Category I during this biennium. CME information booklets are currently being printed and will be mailed to all physicians upon availability. Please keep the Board informed of any address changes.

Again, thank you for your cooperation.

Very truly yours,

Henry G. Cramblett, M.D.
Secretary
OHIO STATE MEDICAL BOARD

HGC:jmb

OK

208 GRAYLING DR. NE
AKRON OH 44313

Dear Doctor:

Upon renewal of your Ohio license to practice medicine and surgery, as of December 31, 1988, you certified that during the last biennium (January 1, 1987-December 31, 1988) you had completed the requisite hours of Continuing Medical Education certified by the Ohio State Medical Association.

At this time, as a routine and random audit procedure, it will be necessary for you to complete the enclosed log of Continuing Medical Education. It will also be necessary for you to provide the Board with documentation that you have actually completed at least 40 hours of Category I CME as certified on your license renewal application. Certificates of attendance, hospital printouts and accredited organization printouts are acceptable documentation, copies of which must be enclosed with your log.

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

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

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

Thank you for your cooperation.

Sincerely,

Henry G. Cramblett, M.D.
Secretary
OHIO STATE MEDICAL BOARD

HGC:jmb
Enclosures:

CERTIFIED MAIL # P 746 513 848
RETURN RECEIPT REQUESTED

revised 06-06-89

...OG OF CONTINUING MEDICAL EDUCATION
FOR THE PERIOD OF JANUARY 1, 1987 - DECEMBER 31, 1988

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

SIGNATURE Lorinda E. Ely (Mrs. M.D.) DATE July 7 1989

NAME 208 · Hawthorne Dr.

ADDRESS Akron Ohio 44313

07 1989

OHIO CERT # 0322759

CATEGORY I

PLEASE ATTACH DOCUMENTATION

100 CREDIT REQUIREMENT
At least 40 credits must be earned in Category I. Please list Category II credits on the reverse side (maximum 60).

Name of Sponsor	Location	Description	Date	Credits
ACOG - UPDATE	P.O Box 1520 Port Washington NY 11050	Post test Review 12 issues 3 Cat I each issue	Jan 1987 to Dec 1987	36.
ACOG - Update	P.O Box 1520 Port Washington NY 11050	Post test Review 12 issues 3 cat I each issue	Jan 1988 to Dec 1988	36
St. Thomas med. Center	444 N. Main St. AKRON. OHIO 44310	Post Test "The Autopsy"	3/31/87	3.
Northeastern Ohio University College of medicine	Rootstown, OHIO	update in OB GYN 1987	10/9/87	6.25
Association of Reproductive Health Professional / APPFA	BOSTON, MA	"Medical Risk Reduction Summary"	11/21/87	7.5
Assn. of Reproductive Health Professional / PPFA	Boston MA	"Women at Risk" Summary	11/20/87	7.5
Yale School of medicine and the medical Letter	5/6 Arnold St. Also Rochester NY	Examination #15 Test on 6 issues of med. letter	Jan 1987	13
Yale School of medicine	Same	Examination #16	July 1987	13
Yale School of med. and "Medical Letter"	Same	Exams # 17 & 18	Jan 1988 July 1988	26
University of Illinois Symposium on Obstetrics	Chicago, Illinois	Series of lectures on various medical topics	5/31-6/3/88	14.5
Association of Philippine Physicians in America	Manila, Philippines	Lectures on various med. topics	Dec 15-16	10
			Total	171.75

CATEGORY II 60 credits may be earned in this Category.

Name of Activity	Description	Date	Credits
Reading of Contraception OB-GYN		Every Issue 1 ½/yr.	
Teaching medical students on use of Contraception Pelvic Exams		2 hrs/week	

SENDER: Complete items 1 and 2 when additional services are desired, and complete items 3 and 4.
Put your address in the "RETURN TO" Space on the reverse side. Failure to do this will prevent this card from being returned to you. The return receipt fee will provide you the name of the person delivered to and the date of delivery. For additional fees the following services are available. Consult postmaster for fees and check box(es) for additional service(s) requested.
1. ☐ Show to whom delivered, date, and addressee's address. *(Extra charge)*
2. ☐ Restricted Delivery *(Extra charge)*

3. Article Addressed to:

CHAND, ERLINDA E. UY
208 GRAYLING DR. W.
AKRON OH 44313

4. Article Number
P 746 513 848

Type of Service:
☐ Registered ☐ Insured
☑ Certified ☐ COD
☐ Express Mail ☐ Return Receipt for Merchandise

Always obtain signature of addressee or agent and DATE DELIVERED.

5. Signature — Addressee
X David V. Chand - SOM

6. Signature — Agent
X

7. Date of Delivery
7389

8. Addressee's Address *(ONLY if requested and fee paid)*

PS Form 3811, Mar. 1988 * U.S.G.P.O. 1988-212-865 DOMESTIC RETURN RECEIPT

P 746 513 848
RECEIPT FOR CERTIFIED MAIL
NO INSURANCE COVERAGE PROVIDED
NOT FOR INTERNATIONAL MAIL
(See Reverse)

CHAND, ERLINDA E. UY
208 GRAYLING DR. W.
AKRON OH 44313

Postage	$
Certified Fee	
Special Delivery Fee	
Restricted Delivery Fee	
Return Receipt showing to whom and Date Delivered	
Return Receipt showing to whom Date, and Address of Delivery	
TOTAL Postage and Fees	$
Postmark or Date	

PS Form 3800, June 1985

Fold at line over top of envelope to the right of the return address

VOLUME 13

ACOG UPDATE

Participation in each issue of this Continuing Medical Education activity, meets the criteria for 3 hours of credit in Category 1 toward the Physician's Recognition Award of the AMA and 3 "cognates" in the Continuing Professional Development Program of the ACOG. CME credit will be recorded automatically into the records of Fellows and Junior Fellows of the ACOG.

CONFIDENTIAL POST-TEST HISTORY REPORT

ISSUE NO.	DATE ENTERED	SCORE	QUESTIONS ANSWERED INCORRECTLY ARE INDICATED BELOW, FOLLOWED BY THE CORRECT RESPONSES AND REFERENCE TO THEIR LOCATION WITHIN THE TRANSCRIPT [PAGE/PARAGRAPH].
1	09/04/87	92%	6D- 3/7+
2	09/09/87	100%	
3	11/04/87	67%	1A- 1/1 6B- 4/9 7A- 4/9+ 12B- 9/2
4	11/09/87	100%	
5	03/08/88	83%	3A- 3/11 9A- 6/14
6	03/16/88	100%	
7	03/16/88	83%	2D- 1/17 12B- 7/11
9	05/23/88	83%	3B- 2/1 6A- 4/21
10	10/06/88	100%	
11	10/06/88	83%	2C- 3/2+ 6D- 4/5+
12	10/06/88	75%	2B- 7/2 4C- 1/13 9D- 5/9
CUMULATIVE SCORE:		88%	

ERLINDA E CHAND MD
208 GRAYLING DRIVE WEST
AKRON OH

44313-

JUL 07 198

REGISTRATION NO. 007595 CE #

VOLUME 12

ACOG UPDATE

Participation in each issue of this Continuing Medical Education activity, meets the criteria for 3 hours of credit in Category 1 toward the Physician's Recognition Award of the AMA and 3 "cognates" in the Continuing Professional Development Program of the ACOG. CME credit will be recorded automatically into the records of Fellows and Junior Fellows of the ACOG.

CONFIDENTIAL POST-TEST HISTORY REPORT

ISSUE NO.	DATE ENTERED	SCORE	QUESTIONS ANSWERED INCORRECTLY ARE INDICATED BELOW, FOLLOWED BY THE CORRECT RESPONSES AND REFERENCE TO THEIR LOCATION WITHIN THE TRANSCRIPT [PAGE/PARAGRAPH].
1	10/31/86	92%	9C- 6/4
2	11/19/86	75%	1D- 1/11 2C- 6/23 4D- 2/7+
3	12/02/86	75%	1C- 1/1 5D- 4/9+ 8A- 3/5+
4	01/14/87	100%	
5	01/16/87	100%	
6	03/16/87	83%	10D- 5/4 12B- 7/18
7	03/18/87	92%	1D- 3/2
8	05/26/87	75%	7D- 5/8 9C- 4/7 11B- 3/13
9	05/28/87	67%	8A- 4/7 9D- 1/12 10D- 6/10 11C- 6/5
10	05/28/87	100%	
11	08/31/87	100%	
CUMULATIVE SCORE:		87%	

ERLINDA E CHAND MD
208 GRAYLING DRIVE WEST
AKRON OH

44313

JUL 07 1988

REGISTRATION NO. 00759

CE #

VOLUME 14

ACOG UPDATE

Participation in each issue of this Continuing Medical Education activity, meets the criteria for 3 hours of credit in Category 1 toward the Physician's Recognition Award of the AMA and 3 "cognates" in the Continuing Professional Development Program of the ACOG. CME credit will be recorded automatically into the records of Fellows and Junior Fellows of the ACOG.

CONFIDENTIAL POST-TEST HISTORY REPORT

ISSUE NO.	DATE ENTERED	SCORE	QUESTIONS ANSWERED INCORRECTLY ARE INDICATED BELOW, FOLLOWED BY THE CORRECT RESPONSES AND REFERENCE TO THEIR LOCATION WITHIN THE TRANSCRIPT [PAGE/PARAGRAPH].
1	11/30/88	92%	2C- 2/6
2	11/30/88	83%	5B- 2/8 11B- 6/10
3	11/30/88	75%	5D- 3/11 6B- 3/13 8B- 5/4
4	12/01/88	75%	3B- 2/9+ 5A- 5/4+ 9C- 2/9+
5	01/19/89	92%	10C- 6/5
6	01/18/89	75%	4D- 7/13 7D- 6/1 9C- 8/9
7	01/19/89	83%	3C- 4/1 9D- 8/8
8	03/08/89	83%	6B- 7/16 8B- 8/18
9	03/30/89	92%	7C- 4/6+
CUMULATIVE SCORE:		83%	

ERLINDA E CHAND MD
208 GRAYLING DRIVE WEST
AKRON OH

44313-

JUL 07 1989

REGISTRATION NO. 007595 CE #

9/08/87

SAINT THOMAS HOSPITAL MEDICAL CENTER
CONTINUING MEDICAL EDUCATION DOCTOR'S SUMMARY

PAGE

FOR: ERLINDA E CHAND

SOCIAL SECURITY NUMBER: [redacted] OHIO CERTIFICATE NUMBER: 032759

MEDICAL EDUCATION NUMBER 74801631855

CLASS TITLE	CLASS DATE	HOURS	CATEG
THE AUTOPSY	3/31/87	3.0	1

TOTAL HOURS FOR CATEGORY 1: 3.0 TOTAL HOURS FOR CATEGORY 2: .0

JUL 07 1988

Northeastern Ohio Universities COLLEGE OF MEDICINE

The Program in Continuing Medical Education certifies that

Erlinda Chand, M.D.

is awarded 6.25 *Category I credit hours for participation in*

UPDATE IN OBSTETRICS AND GYNECOLOGY 1987
OCTOBER 9, 1987

JUL 07 1988

Alvin Langer, M.D.
Program Director

Robert M Bunsan M.D.
Chairperson, Committee on Continuing Medical Education

Provost and Dean

ARHP

Association of Reproductive Health Professionals / PPFA

Certificate of Attendance

Medical Risk Reduction Seminar
November 21, 1987
Boston, MA

This Certifies the Attendance of

Erlinda Chand, M.D.

ARHP is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

ARHP designates this continuing medical education activity for 7 credit hours in Category I of the Physicians Recognition Award of the American Medical Association.

This course has been approved for 7 cognates, Formal Learning, by the American College of Obstetricians and Gynecologists.

Michael S. Bamford

President
Association of Reproductive Health Professionals

JUL 07 1988

ARHP

Association of Reproductive Health Professionals

Certificate of Attendance

Women at Risk
November 20, 1987

This Certifies the Attendance of

Erlinda Chand

ARHP is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

ARHP designates this continuing medical education activity for 7 credit hours in Category I of the Physicians Recognition Award of the American Medical Association.

This course has been approved for 7 cognates, Formal Learning, by the American College of Obstetricians and Gynecologists.

Michael S. Ramboldt

President
Association of Reproductive Health Professionals

JUL 07 1989

ERLINDA CHAND MD
208 GRAYLING DR W
AKRON,OH 44313

The Medical Letter®

and

the Yale School of Medicine

continuing medical education program

This is to certify that ERLINDA CHAND MD

has successfully completed EXAM NO. 15 JANUARY 1987

and is therefore awarded 13 credits in Category 1 for Educational Materials.

As an organization accredited by the Accreditation Committee for Continuing Medical Education, Yale University School of Medicine has designated this continuing medical education activity as meeting the criteria for 13 credit hours in Category 1 for Educational Materials for the Physician's Recognition Award of the American Medical Association or any other organization that recognizes such Category 1 credit.

The program has also been reviewed and is acceptable for 13 prescribed hours by the American Academy of Family Physicians.

Additional accreditations of the program have been listed in the examination booklets. They can be supplied on request.

JUL 07 1989

James D. Kenney, M.D.

Associate Dean for Graduate and Continuing Education
Yale University School of Medicine

ERLINDA CHAND MD
208 GRAYLING DR W
AKRON, OH 44313

The Medical Letter®

and

the Yale School of Medicine

continuing medical education program

This is to certify that ERLINDA CHAND MD

has successfully completed EXAM NO. 16 JULY 1987

and is therefore awarded 13 credits in Category 1 for Educational Materials.

JUL 07 1989

Yale University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Yale University School of Medicine has designated this continuing medical education activity as meeting the criteria for 13 credit hours in Category 1 for Educational Materials for the Physician's Recognition Award of the American Medical Association or any other organization that recognizes such Category 1 credit.

The program has also been reviewed and is acceptable for 13 prescribed hours by the American Academy of Family Physicians.

Additional accreditations of the program have been listed in the examination booklets. They can be supplied on request.

James D. Kenney, M.D.
Associate Dean for Graduate and Continuing Education
Yale University School of Medicine

ERLINDA CHAND MD
208 GRAYLING DR W
AKRON, OH 44313

The Medical Letter®

and

the Yale School of Medicine

continuing medical education program

This is to certify that ERLINDA CHAND MD

has successfully completed EXAM NO. 17 JANUARY 1988

and is therefore awarded 13 credits in Category 1 for Educational Materials.

JUL 07 1989

Yale University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Yale University School of Medicine has designated this continuing medical education activity as meeting the criteria for 13 credit hours in Category 1 for Educational Materials for the Physician's Recognition Award of the American Medical Association or any other organization that recognizes such Category 1 credit.

The program has also been reviewed and is acceptable for 13 prescribed hours by the American Academy of Family Physicians.

Additional accreditations of the program have been listed in the examination booklets. They can be supplied on request.

James D. Kenney, M.D.
Associate Dean for Graduate and Continuing Education
Yale University School of Medicine

ERLINDA CHAND MD
208 GRAYLING DR W
AKRON,OH 44313

The Medical Letter®

and

the Yale School of Medicine

continuing medical education program

This is to certify that ERLINDA CHAND MD

has successfully completed EXAM NO. 18 JULY 1988

and is therefore awarded 13 credits in Category 1 for Educational Materials.

JUL 07 1988

Yale University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Yale University School of Medicine has designated this continuing medical education activity as meeting the criteria for 13 credit hours in Category 1 for Educational Materials for the Physician's Recognition Award of the American Medical Association or any other organization that recognizes such Category 1 credit.

The program has also been reviewed and is acceptable for 13 prescribed hours by the American Academy of Family Physicians.

Additional accreditations of the program have been listed in the examination booklets. They can be supplied on request.

James D. Kenney, M.D.
Associate Dean for Postgraduate and Continuing Medical Education
Yale University School of Medicine

UNIVERSITY OF SANTO TOMAS
MEDICAL ALUMNI OF THE MIDWEST

AMA CATEGORY 1 CREDIT
CONTINUING MEDICAL EDUCATION

CONTINUING MEDICAL EDUCATION COMMITTEE

THIS IS TO CERTIFY THAT

ERLINDA UY CHAND, M.D.

HAS COMPLETED THE FOLLOWING NUMBER OF HOURS OF CONTINUING MEDICAL EDUCATION, APPROVED FOR AMA
14 1/2 *CATEGORY 1 CREDIT SPONSORED BY THE SOCIETY OF PHILIPPINE SURGEONS IN AMERICA.*

MAY 27-30, 1988 CHICAGO IL

PRESIDENT

CHAIRMAN, CONTINUING EDUCATION COMMITTEE

JUL 07 198

UNIVERSITY OF SANTO TOMAS
FACULTY OF MEDICINE AND SURGERY

This certifies that

Erlinda Uy-Chand, M.D.

has attended the

ALIMURUNG MEMORIAL POSTGRADUATE COURSE

for

OVERSEAS MEDICAL ALUMNI

Given in Manila, Philippines, Dec. 15-16 , 1988

Dean

Director, Continuing Medical Education

Regent

Program Director

JUL 07 1989

As a medical organization accredited for Continuing Medical Education, the Association of Philippine Physicians in America certifies that this medical education activity meets the criteria for 10 hours in Category I of the American Medical Association Physician recognition award.

STATE OF OHIO STATE MEDICAL BOARD
65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE
I DO SWEAR OR AFFIRM THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN
AS APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Erlinda E. Chand M.D. 12/8/84
(SIGNATURE OF APPLICANT) (DATE)

INSTRUCTIONS
1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438 COLUMBUS, OHIO 43216

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
35-03-2759

1
ERLINDA E. UY CHAND
208 GRAYLING DR. W.
AKRON OH 44313

MD & DO SPECIALTY CODES
SPECIALTY CODES CURRENTLY ON RECORD → 39
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS → 39
(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00

DATE DUE 11/15/84

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)
LAST NAME FIRST NAME INITIAL
STREET ADDRESS
CITY STATE ZIP CODE
COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY DUE DATE.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS — IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL
STREET ADDRESS
CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER Redacted

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN CONVICTED OF OR PLEAD NOLO CONTENDERE TO:

YES	NO	
☐	☒	a.) a felony,
☐	☒	b.) a misdemeanor committed in the course of your practice, or
☐	☒	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO		YES	NO	
☐	☒	1). Been addicted to or dependent upon alcohol or any chemical substance?	☐	☒	3). Surrendered or consented to limitation of a license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☒	2). Had any disciplinary action taken or initiated against you by a state licensing agency?	☐	☒	4). Had any hospital privileges suspended or revoked?

STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY 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 ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Erlinda Chand MD 10/12/86
(SIGNATURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
35-03-2759

ERLINDA E. UY CHAND
208 GRAYLING DR. W.
AKRON OH 44313

MD & DO SPECIALTY CODES
ENTER ALL SPECIALTY CODES → 21 (LIMIT OF 3)
(SEE LIST ON ENCLOSED CARD)

AMOUNT DUE $100.00

DATE DUE 11/15/86

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 15

INSTRUCTIONS
1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO:
TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS – IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER Redacted

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☑	a.) a felony.
☐	☑	b.) a misdemeanor committed in the course of your practice, or
☐	☑	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO	
☐	☑	1.) Been addicted to or dependent upon alcohol or any chemical substance?
☐	☑	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☑	3.) Surrendered or consented to limitation [illegible] license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☑	4.) Had any hospital privileges suspended or revoked?

EDM-14946-B

STATE MEDICAL BOARD OF OHIO

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY 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 ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Erlinda E. Uy Chand
(SIGNAURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A; DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-03-2759

ERLINDA E. UY CHAND
208 GRAYLING DR. W.
AKRON OH 44313

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD) 21 (LIMIT OF 3)

AMOUNT DUE $100.00

DATE DUE 11/01/88

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. UPDATE SPECIALTY IF NEEDED.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438, COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME | FIRST NAME | INITIAL

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 1.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME | FIRST NAME | INITIAL

STREET ADDRESS

CITY | STATE | ZIP CODE

SOCIAL SECURITY NUMBER Redacted

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☑	a.) a felony
☐	☑	b.) a federal or state law regulating the possession, distribution or use of any drug?

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

YES	NO	
☐	☑	1.) Been addicted to or dependent upon alcohol or any chemical substance? 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 statuatory requirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.
☐	☑	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☑	3.) Surrendered or consented to limitation upon a license to practice medicine or state or federal privileges to prescribe controlled substances?
☐	☑	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-03

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 Erlinda E. Uy-Chand MD 9/29/90

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-03-2759	$160.00	11/01/90

ERLINDA E. UY CHAND, M.D.
208 GRAYLING DR. W.
AKRON OH 44313

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

21 GYNECOLOGY

X SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1: 319 CODE2: CODE3:

0 X CHANGE OF ADDRESS Zip Code Error

STREET
STREET
CITY OH STATE 44313 ZIP CODE
COUNTY

Please note change of zip code #

:96969696 21: 0935032759 00000 16000

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

Planned Parenthood Assn.
Street
Street
Akron OH 44305
City State Zip Code
County

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

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

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

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

YES NO
☐ ☒ 2.) Had any disciplinary action taken or initiated against you by any state licensing board?

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

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

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 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 Erlinda E. Uy-Chand, MD 6/6/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-2759	$160.00	07/01/92

ERLINDA E. UY CHAND,M.D.
208 GRAYLING DR. W.
AKRON OH 44333

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

21 GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1: 39 CODE2: CODE3:

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935032759 00000160000

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

Street
Street
City State Zip Code
County

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

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

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

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

Redacted

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 Erlinda Chand MD 3/30/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-2759	$250.00	05/01/94

ERLINDA E. UY CHAND,M.D.
208 GRAYLING DR. W.
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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935032759 ' 00000 25000 '

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
348 HIGH ST
Street
AKRON OH 44326
City State Zip Code
SUMMIT
County

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

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES ☐ NO ☒
2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☒
3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES ☐ NO ☒
4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES ☐ NO ☑
5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES ☐ NO ☑
6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES ☐ NO ☑
7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES ☐ NO ☑
8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any [illegible] arrangement? YES ☐ NO ☑

1 MC 250.00 040494 935032759
AMOUNT BATCHDATE ACCOUNT #

Redacte

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 Erlinda Uy Chand MD 3/11/96

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-2759	$250.00	05/01/96

ERLINDA E. UY CHAND,M.D.
208 GRAYLING DR. W.
AKRON OH 44333

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

PROCESSED ☐ 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: 0935032759" "0000025000"

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

Street
Street: 34 SOUTH HIGH ST
City: AKRON State: OH Zip Code: 44308
County:

0383 00047 031196 01 3 / PAY BATCH P DATE MC#

250.00 AMOUNT 031496 BATCHDATE

935032759 ACCOUNT #

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.

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?

[redacted]

(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 Erlinda E. Uy-Chand, M.D. 3/9/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-2759-C	$339.00	05/01/98

ERLINDA E. UY CHAND,M.D.
208 GRAYLING DR. W.
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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935032759 "0000033900"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
34 SOUTH HIGH ST.
Street
c/o PLANNED PARENTHOOD
Street
AKRON OH 44308
City State Zip Code
Summit
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 [redacted] YES ☐ NO ☑

AMOUNT PAID 339.00 DATE 03/09/98
935032759
ACCOUNT #

MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principle Practice address.

208 W. GRAYLING DR
Street

AKRON OH 44333
City State Zip Code

SUMMIT
County

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?	☐	X
2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question if** you have successfully completed treatment at 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
3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?	☐	X
4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board,** filed any charges, allegations or complaints against you?	☐	X
5.) Have you surrendered, or consented to limitation of 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.	☐	X
6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**	☐	X

Redac

SOCIAL SECURITY NUMBER

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 Erlinda E Uy Chand MD 10/4/0
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-2759-C	$305.00	01/01/2001

ERLINDA E. UY CHAND,M.D.
208 GRAYLING DR. W.
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. GYN (CODE1) (CODE2) (CODE3)

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

208 W. GRAYLING DR
STREET

STREET

FAIRLAWN OH 44333
CITY STATE ZIP CODE

SUMMIT
COUNTY

MAILING ADD.

:969696962: 0935032759 000003050

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 2001 - 2003 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 Erlinda Uy Chand M.D 10/08/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-03-2759-C	$305.00	01/01/03	04/01/03

ERLINDA E. UY CHAND,M.D.
208 W GRAYLING DR
FAIRLAWN OH 44333

0935032759 30500

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
GYN 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

208 W GRAYLING DR.
STREET
STREET
FAIRLAWN OH 44333
CITY STATE ZIP CODE
SUMMIT
COUNTY

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.

444 W. EXCHANGE ST.
Street
AKRON OH 44302
City State Zip Code
SUMMIT
County

0179 090
0935032759
I SE 000030500

Redacted

Date Posted: 12/11/2004 12:37:04 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

CREDENTIAL MAIL ADDRESS

208 W GRAYLING DR
FAIRLAWN, OH 44333
Summit County
United States of America
(330) 867-8179

License Information

License Number 35.032759
License Name ERLINDA CHAND
Email Address

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

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

Discipline

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

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

..... NO

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

..... NO

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

..... NO

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

..... NO

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

..... NO

Social Security Number

1. ... Redacted

Nurse Collaboration Info

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

..... YES

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

..... Ingrid Kissinger, CNP; Marcellia Stephens, CNP; Carol Stevens, CNP; Gretchen Peterson, CNP; Ruth Moehler, CNP; Emily Wilford, CNP; Tanya Fulk, CNP

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

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

Date Posted: 10/8/2006 12:29:52 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	444 W EXCHANGE ST AKRON, OH 44302 Summit County United States of America (330) 535-2671

License Information

License Number	35.032759
License Name	ERLINDA CHAND
Email Address	chand_david@hotmail.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?

. . . . . YES

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

. . . . . Ingird Kissinger, CRNP; Carol Stevens, CRNP; Marcellia Stephens, CRNP; Emily Wilford, CRNP; Ruth Moeller, CRNP; Virginia Melver, CRNP

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: 11/9/2008 7:48:54 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	208 West Grayling Drive Fairlawn, OH 44333 Summit County United States of America (330) 867-8179 lindaeuymd@att.net
CREDENTIAL MAIL ADDRESS	208 W GRAYLING DR FAIRLAWN, OH 44333 Summit County United States of America (330) 867-8179 lindaeuymd@att.net
MAIN	208 W GRAYLING DR FAIRLAWN, OH 44333 Summit County United States of America (330) 867-8179 lindaeuymd@att.net

License Information

License Number	35.032759
License Name	ERLINDA CHAND
Email Address	chand_david@hotmail.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, 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: 11/11/2010 4:10:52 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	35.032759
License Name	ERLINDA CHAND

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.

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 10-14

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.

. 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).

. 10-14

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

. 0

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 44240

2. Enter the first county:

. . . . . Summit

3. Enter the second zip code:

. 44266

4. Enter the second county:

. . . . . Portage

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?

. . . . . 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.

Date Posted: 10/16/2012 9:34:03 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	35.032759
License Name	ERLINDA CHAND

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 10-14

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

. 10-14

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

. 0

Clinical - Practice setting

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

. 10-14

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

. 0

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 44333

2. Enter the first county:

. . . . . Summit

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

. . . . . YES

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . 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.