STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

APP-SENT 5/2/89

PLEASE TYPE OR PRINT CLEARLY

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

NAME: SMITH (LAST (Surname)) TARI (FIRST) SUZANNE (MIDDLE) (SUFFIX (Jr., II))

ADDRESS: 8302 CURZON AVE (STREET & NUMBER) CINCINNATI (CITY) OH (STATE) 45216 (ZIP) HAMILTON (COUNTRY)

TELEPHONE: BUSINESS: (513) 369-2000 (ext) (AREA CODE & NUMBER) HOME: (513) 761-8184 (AREA CODE & NUMBER)

BIRTH DATE: 06/27/62 (MO/DAY/YR) BIRTH PLACE: WAHIAWA (CITY) HA (STATE) USA (COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: WRIGHT STATE (SCHOOL NAME) COL. GLENN HWY (STREET ADDRESS) FAIRBORN (CITY) OH (STATE) USA (COUNTRY)

9/ 1/84 (FROM (date)) TO 6/11/88 (date) M.D (DEGREE RECEIVED) 6/11/88 (DATE RECEIVED)

OTHER MEDICAL SCHOOLS ATTENDED: (IF "NONE ENTER "NONE") NONE (SCHOOL NAME) (STREET ADDRESS) (CITY) (STATE) (COUNTRY)

/ / (FROM (date)) 6/11/88 (TO (date)) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

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

/ / (FROM (date)) / / (TO (date)) (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: (IF "NONE", ENTER "NONE") (HOSPITAL OR INSTITUTION) AFFILIATED WITH: (NAME OF MEDICAL SCHOOL)

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: UNIVERSITY OF CINCINNATI (NAME) 234 GOODMAN (STREET ADDRESS) CINCINNATI (CITY) OH (STATE)

POSITION: PGY I DEPARTMENT: OB/GYN DATE: 7/1/88 (FROM) / / present (TO ~ 7-1-92)

HOSPITAL: (NAME) (STREET ADDRESS) (CITY) (STATE)

POSITION: DEPARTMENT: DATE: / / (FROM) / / (TO)

HOSPITAL: (NAME) (STREET ADDRESS) (CITY) (STATE)

POSITION: DEPARTMENT: DATE: / / (FROM) / / (TO)

HOSPITAL: (NAME) (STREET ADDRESS) (CITY) (STATE)

POSITION: DEPARTMENT: DATE: / / (FROM) / / (TO)

APR 24 1989

LICENSES IN OTHER COUNTRIES

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

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

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

LICENSES IN THE UNITED STATES

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

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

BASIS OF LICENSURE: _____

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

BASIS OF LICENSURE: _____

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

BASIS OF LICENSURE: _____

STATE BOARD OR FLEX EXAMINATIONS TAKEN

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

STATE: OH DATE TAKEN: 3-1-89 PASS: X FAIL: ____ FULL (X) PARTIAL ( )

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

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

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

ADDITIONAL ELIGIBILITY INFORMATION -ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? YES ___ NO X DATE __/__/__

DIPLOMATE OF THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS? YES___ NO X DATE __/__/__

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

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

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.?

YES_____ NO_____

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

IF YES, GIVE FULL ADDRESS AT THAT TIME:

2966 Olentangy River Rd	Delaware	OH	43015
STREET ADDRESS	CITY	STATE	ZIP

CERTIFICATION

I, TARI SMITH, HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING SCREENING FORM; THAT THE STATEMENTS THEREIN ARE STRICTLY TRUE IN EVERY RESPECT AND THAT I HAVE READ AND UNDERSTAND THIS CERTIFICATION.

Tari Smith 4-20-89

SIGNATURE DATE

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

Ohio
Fee Unit Circle
7-20-89

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)

Smith	Tari	Suzanne	
LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)

3. NAME (As you prefer it inscribed on your Ohio license)

Smith	Tari	S.	
LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)

4. ALTERNATE NAMES (IF "NONE" ENTER "NONE")

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

5. CURRENT ADDRESS 8302 Curzon Ave.
STREET NUMBER & NAME

Cincinnati	Ohio	45216	U.S.A.
CITY	STATE	ZIP CODE	COUNTRY

6. PHYSICAL DESCRIPTION

5'3"	110	brown	brown	none
HEIGHT	WEIGHT	HAIR COLOR	COLOR OF EYES	IDENTIFYING MARKS

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

8. CITY IN OHIO WHERE YOU PLAN TO PRACTICE: _____ Hamilton
CITY OR COUNTY

PLANS OF PRACTICE: general OB/GYN

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

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

FOR OFFICE USE ONLY 34 Ent 35

1-6
52-10-146
6-26-89
185.00 pe 910

JUN 26 1989

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

RESUME

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

Smith, Tari

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
a. 07 / 88 month year TO 06 / 89 month year	University of Cincinnati General Hospital Hospital/University/Other 234 Goodman St. Cincinnati, OH 45267 Street Address City/State Zip	PGI in OB/GYN	100	
b. month year TO month year	Hospital/University/Other Street Address City/State Zip			
c. month year TO month year	Hospital/University/Other Street Address City/State Zip			
d. month year TO month year	Hospital/University/Other Street Address City/State Zip			
e. month year TO month year	Hospital/University/Other Street Address City/State Zip			

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

ADDITIONAL INFORMATION

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

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

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

FORM 1

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, Robert W. Rebar, a licensed and practicing physician in the state of
Name of Recommending Physician
Ohio affirm that Tari Suzanne Smith, has been known
Name of Applicant
to me personally and professionally for 1 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Excellent
His/her command of the English language is: Excellent
I rate his/her ability to work well with peers and medical staff as: Excellent
His/her relationship with patients is: Excellent
Additional comments: Dr. Smith did a very fine job as an intern in our Institution

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

x Robert W. Rebar
Signature of Recommending Physician

Robert W. Rebar, M.D.
Name of Recommending Physician
(Please print or type)

231 Bethesda Avenue
Cincinnati, Ohio 45267-0526
Address of Recommending Physician
(Include City, State, Zip)

513/558-8440
Telephone Number
(Include Area Code)

(SEAL)

56694 Ohio
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 20th day of June, 1989.

Barbara B. Burnett
Notary Public

BARBARA B. BURNETT
Notary Public, State of Ohio
My Commission Expires June 15, 1993
Date Commission Expires

Upon completion return to:

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

Tari Smith
Signature of Applicant

2/89
Date Photo Taken

JUN 26 1989

AMG

FORM 1

CERTIFICATE OF RECOMMENDATION

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

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, Tom P. Barden, a licensed and practicing physician in the state of
Name of Recommending Physician
Ohio affirm that Tari Suzanne Smith, has been known
Name of Applicant
to me personally and professionally for 1 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

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

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

T. P. Barden
Signature of Recommending Physician

Tom P. Barden, M.D.
Name of Recommending Physician
(Please print or type)

231 Bethesda Avenue
Cincinnati, Ohio 45267-0526
Address of Recommending Physician
(Include City, State, Zip)

513/558-8440
Telephone Number
(Include Area Code)

(SEAL)

030722 OHIO
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 20th day of June, 1989.

Barbara B. Burnett
Notary Public

BARBARA B. BURNETT
Notary Public, State of Ohio
My Commission Expires June 15, 1993
Date Commission Expires

Upon completion return to:

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

Signature of Applicant

3/89
Date Photo Taken

JUN 26 1989

***THIS FORM SHALL NOT BE COMPLETED MORE THAN 30 DAYS PRIOR TO COMPLETION OF TRAINING.

AD

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 Boar 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 TARI SUZANNE SMITH (Name of Applicant) has rendered satisfactory and continuous service as a(n) [X] intern [ ] resident [ ] clinical fellow in Ob/Gyn (Department)

at University of Cincinnati Hospital (Name of Hospital), 234 Goodman Ave., Cincinnati, OH 45267 (Complete Address of Hospital)

from July 1, 1988 beginning (month/day/year) to June 30, 1989 ending (month/day/year). It is further certified that the above name [ ] was awarded a certificate on _____ (month/day/year) [X] was not

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

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

(SEAL OF HOSPITAL)

Tom P. Barden, M.D.
Name (Please print or type)

JUNE 16, 1989
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

0

JUN 26 1989

AFFIDAVIT AND RELEASE

AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF Ohio

COUNTY OF Hamilton

I, Tari Suzanne Smith, 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, tha 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 applicatio 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 instruction 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 wil be privileged.

I further understand that failure to complete this application as requested by the Board withi 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 dat 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 th 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.

Tari Smith
Signature of Applicant

Subscribed and sworn to before me this 14th day of June 1989.

Barbara B. Burnett
Notary Public Signature

BARBARA B. BURNETT
Notary Public, State of Ohio
My Commission Expires June 15, 1993

(NOTARY SEAL)

Date Commission Expires

JUN 26 1989

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO 75123

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 D. Bourquin

Entrance Examiner

Harry S. Crawford M.D.

Secretary

9-7-89

Date Issued

FOR BOARD USE ONLY

32021

NAME: Smith, Jane S.

CERTIFICATE #: 58827 DATE ISSUED 9-15-89

FILED May 2, 19 89

FEE

DETERMINATION:

BOARD ACTION: 9/89 Bd

BASIS OF LICENSURE:

52-10

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

acl

PRELIMINARY EDUCATION FORM

My name IN FULL is SMITH (LAST) TARI (FIRST) SUZANNE (MIDDLE)

High School or Equivalent:

SCHOOL NAME	CITY	STATE	COUNTRY
OLENTANGY HIGH	DELAWARE	OH	USA

FROM (DATE)	TO (DATE)	DEGREE
9/176	6/180	YES

Undergraduate College or Equivalent:

SCHOOL NAME	CITY	STATE	COUNTRY
OHIO STATE UNIV	COLUMBUS	OH	USA

FROM (DATE)	TO (DATE)	DEGREE
9/180	3/184	BS

5/23 9/7/89

SCHOOL NAME	CITY	STATE	COUNTRY

FROM (DATE)	TO (DATE)	DEGREE
/ /	/ /	

Medical School of Graduation:

SCHOOL NAME	CITY	STATE	COUNTRY
WRIGHT STATE	FAIRBORN	OH	USA

FROM (DATE)	TO (DATE)	DEGREE
9/184	6/11/88	MD

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: _____

DATE ISSUED: _____

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

APR 24 1989

Univ of Cincinnati

7/13

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

DATE July 20, 1989

Dear Doctor:

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

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

(2) What was/is your supervisory capacity? teacher.

(3) At what hospital? University of Cincinnati

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

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

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

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

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

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

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

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

April Davidson
Licensure Assistant

T.P. Barden

Signature of Doctor, please type or print name legibly beneath

TOM P. BARDEN MD.

Professor of OB Gyn.
Position

DATE: 7/24/89.

Telephone No. 513 558 8440 (Include Area Code)

AUG - 9 1989

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

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Tari Suzanne Smith, M.D.

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

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

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

Philadelphia, Pa.
07/01/89

Certificate # 356059

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from WRIGHT STATE U SCH OF MED in JUNE 1988 and whose birth date is 06/06/1962. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/86		
Anatomy	435	76
Physiology	430	76
Biochemistry	420	75
Pathology	550	84
Microbiology	520	82
Pharmacology	445	77
Behavioral Sciences	620	88
TOTAL TEST (Minimum Passing Score 380/75	480	79
PART II passed 09/87		
Internal Medicine	525	83
Surgery	635	89
Obstetrics and Gynecology	590	87
Public Health and Preventive Medicine	600	87
Pediatrics	710	92
Psychiatry	610	88
TOTAL TEST (Minimum Passing Score 290/75	635	87
PART III passed 03/89		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75	660	87
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		84

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

Melanie Valente
Secretary for Certification

JUN 26 1989

SEAL

06/22/89
Date

Wright State University

WRIGHT STATE UNIVERSITY SCHOOL OF MEDICINE 1973

By authority of the Board of Trustees and on recommendation of the Faculty hereby confers upon

Tari S. Smith

the Degree of

Doctor of Medicine

With all the honors, rights and privileges belonging thereto.
In Testimony Whereof this Diploma is granted, bearing the Seal of the University and the signatures of its Duly Authorized Officers at Dayton, Ohio,
this eleventh day of June, nineteen hundred and eighty-eight.

Andy J. Hulen
Chair, Board of Trustees

Paige E. Mulhollan
President of the University

AD DOCENDUM INVESTIGANDUM SERVIENDUM
WRIGHT STATE UNIVERSITY 1967

John O. Rudduck, M.D.
Dean

License No- 58827
updated
5/26/94

5-21-94

STATE MEDICAL BOARD
OF OHIO
94 MAY 24 PM 2:11

Dear Sirs,

Please note that I have had I change of name. I am now Tari S. Anderson, I was Tari S. Smith. I have sent my application for license renewal to the treasurer's office (under Tari Smith) I have enclosed a notarized copy of my marriage license.

Thank you for your attention to this matter

Tari Anderson

V.S. 51
5252 06

MELVIN G. RUEGER
Judge of the Court of Common Pleas

586

Court of Common Pleas
Probate Division
Hamilton County

Probate Division
of Hamilton County, Cincinnati, Ohio

State File

STATE MEDICAL BOARD OF OHIO
94 MAY 24 PM 2:11

CERTIFIED ABSTRACT OF MARRIAGE

ML 900846

GROOM	BRIDE
1. Full Name: GREG D ANDERSON	10. Full Name: TARI S SMITH
2. Birth Number (Do not write in this space)	11. Birth Number (Do not write in this space)
3. Age Last Birthday: 33	12. Age Last Birthday: 27
4. Residence (County and State): HAMILTON CO OHIO	13. Residence (County and State): HAMILTON CO OHIO
5. Birthplace (State or Country): MINNESOTA	14. Birthplace (State or Country): HAWAII
6. Occupation: PHYSICIAN	15. Occupation: PHYSICIAN
7. Name of Father: DONALD P ANDERSON	16. Name of Father: TERRY C SMITH
8. Maiden Name of Mother: GAIL K BURKE	17. Maiden Name of Mother: SHIRLEY A BECKLEY
9. Previously Married (Number of Times): 00	18. Previously Married (Number of Times): 00

Previously Married to _____
Divorced: Date _____ *Case No.* _____
Court _____
Minor Children _____
Previously Married to _____
Divorced: Date _____ *Case No.* _____
Court _____
Minor Children _____

The undersigned upon their oath state that the facts set forth in this application are to the best of their knowledge true, and they hereby consent to his marriage.

FATHER _____

MOTHER _____

Previously Married to _____
Divorced: Date _____ *Case No.* _____
Court _____
Minor Children _____
Previously Married to _____
Divorced: Date _____ *Case No.* _____
Court _____
Minor Children _____

The undersigned upon their oath state that the facts set forth in this application are to the best of their knowledge true, and they hereby consent to her marriage.

FATHER _____

MOTHER _____

That neither of said parties is an habitual drunkard, imbecile, or insane person, and is not under the influence of any intoxicating liquor or controlled substance; that said parties are not nearer of kin than second cousins, that there is no legal impediment to their marriage, that _____ *is expected to perform the marriage, and that all of the above statements are true.*

Sworn to before me and signed in my presence, MAR 9 90 _____ 19 ____

Karen Miller *Deputy Clerk*

X _____ M.D.

X _____

MARRIAGE CERTIFICATE

State of Ohio Hamilton County ss:

I do hereby certify that on the 7th *day of* April *A.D. 19* 90 *I performed the marriage of Mr.* Greg D. Anderson *with M* iss Tari S. Smith

Filed and Recorded April 10th 19 90

David E. Ullery - Minister
Clergyman

MELVIN G. RUEGER, Judge

4.7
Ullery

Court of Common Pleas, Probate Division, Hamilton County, Ohio MARCH 19, *19* 90

Marriage license was this day granted to above applicants

MELVIN G. RUEGER, Judge
By Melissa Bedwick *Deputy Clerk*

STATE OF OHIO, COUNTY OF [illegible]
COURT COMMON PLEAS, PROBATE DIVISION
THIS IS TO CERTIFY THAT THE FOREGOING
IS TRUE AND CORRECT COPY OF THE DOCUMENT
ON FILE IN THIS OFFICE ENTERED 4-10-90
WITNESS MY HAND AND SEAL OF SAID COURT
THIS 24 DAY OF April, 1990
MELVIN G. RUEGER, Judge & Ex-Officio Clerk
Shirley Smith, Deputy Clerk

State of Kentucky
County of Boone
I certify that this document is a true and correct copy of the original document.
Mary Ann Sutton
Notary Public
Commission expires:
1-9-98

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 Tari S Anderson 6-6-92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-8827	$160.00	07/01/92

TARI SUZANNE SMITH,M.D.
483 ATTERBURY BLVD
HUDSON OH 44236

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

[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: Tari S Anderson, MD
STREET: 5033 Barnsby Lane
CITY: Cincinnati STATE: OH ZIP CODE: 45244
COUNTY: Clermont

⑆969696962⑆ 0935058827⑈ ⑈0000016000⑈

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

Street
Street: 20 NORTH GRAND AVE
City: Ft Thomas State: KY Zip Code: 41075
County

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

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

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

PROCESSED

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 _____ 5-12-94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-8827	$250.00	05/01/94

TARI SUZANNE SMITH,M.D.
5033 BARNSBY LANE
CINCINNATI OH 45244

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: 0935058827 "00000 25000"

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.

☐ ☒ 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.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

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 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 _____ 3-7-96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-8827	$250.00	05/01/96

TARI SUZANNE ANDERSON,M.D.
5033 BARNSBY LANE
CINCINNATI OH 45244

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

PRICE 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: 0935058827 :00000 25000:

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

Street 5033 Barnsby Lane
Street
City Florence State KY Zip Code 41042
County BOONE

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 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?
AMOUNT 250.00 BATCHDATE 081296
YES NO 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.
ACCOUNT # 35058827
YES NO X

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

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 X

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 X

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

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 X

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 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 _____ 3-6-98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-8827-A	$371.00	05/01/98

TARI SUZANNE ANDERSON,M.D.
5033 BARNSBY LANE
CINCINNATI OH 45244

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

40 NORTH GRAND AVE
STREET
SUITE 204
STREET
FT THOMAS KY 41075
CITY STATE ZIP CODE
CAMPBELL
COUNTY

:96969696 21: 0935058827" "0000037100"

FROM THE ADDRESS SHOWN ON FRONT:
40 North Grand Ave
Street
Suite 204
Street
Ft Thomas KY 41075
City State Zip Code
Campbell
County

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

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

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

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

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

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

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

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

8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement? YES ☐ NO ☒

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

MC# 0018-08 935058827
DATE SEQ# AMOUNT BATCH DATE ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2001 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 _____ 4-5-01
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-8827-A	$305.00	04/01/2001

TARI SUZANNE ANDERSON,M.D.
40 N GRAND AVE
SUITE 204
FT THOMASI KY 41075

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.

850 TEN MILE ROAD
STREET
STREET
NEW RICHMOND OH 45157
CITY STATE ZIP CODE
CLERMONT
COUNTY

:96969696 21: 09350588 27" "0000030500"

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

40 NORTH GRAND AVE
Street
Suite 204
Street
FT THOMAS KY 41075
City State Zip Code
CAMPBELL
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?*

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 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 ☒ 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 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?***

REQUIRED: [redacted]
SOCIAL SECURITY NUMBER

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 [signature] 1-23-03
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-05-8827-A	$305.00	04/01/03	07/01/03

TARI SUZANNE ANDERSON,M.D.
850 TEN MILE RD
NEW RICHMOND OH 45157

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.

STREET 850 Ten Mile Rd
STREET
CITY New Richmond STATE OH ZIP CODE 45157
COUNTY Clermont

0935058827 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 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.
40 N Grand Ave
Street
Street
Ft Thomas KY 41075
City State Zip Code
Campbell
County

REQUIRED: [redacted]

01272003 711700
0000305000
1 SE

Date Posted: 6/10/2005 1:40:02 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	71 E Hollister Street Cincinnati, OH 45219 Hamilton County United States of America 513-723-0909
CREDENTIAL MAIL ADDRESS	71 E Hollister Street Cincinnati, OH 45219 Hamilton County United States of America 513-723-0909
MAIN	850 Ten Mile Road New Richmond, OH 45157 Clermont County United States of America 513-553-0332

License Information

License Number	35.058827
License Name	TARI ANDERSON
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-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.**

. . . . . n/a

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: 1/15/2007 2:16:16 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	71 E Hollister Street Cincinnati, OH 45219 Hamilton County United States of America 513-723-0909
CREDENTIAL MAIL ADDRESS	71 E Hollister Street Cincinnati, OH 45219 Hamilton County United States of America 513-723-0909

License Information

License Number	35.058827
License Name	TARI ANDERSON
Email Address	drskkh@one.net

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 institutionalauthority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 6/4/2009 12:37:28 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	35.058827
License Name	TARI ANDERSON

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?

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Date Posted: 6/14/2011 9:22:34 AM

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

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

License Information

License Number	35.058827
License Name	TARI ANDERSON

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}*

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. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 30-34

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

. 1-4

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.)

. 10-14

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

. 0

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

. 1-4

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).

. 30-34

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

. 5-9

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".

. 1-4

Workforce Counties

1. Enter the first zip code:

. 45230

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45219

4. Enter the second county:

. . . . . Hamilton

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

. 2-5

3. Multi-specialty Group

. . . . . N/A

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

. . . . . 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

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

Date Posted: 5/10/2013 11:22:42 AM

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

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

Address Information

CREDENTIAL MAIL ADDRESS

5777 Kellogg Avenue
Cincinnati, OH 45230
Hamilton County
United States of America
513-232-3232
bariversidegyn@yahoo.com

License Information

License Number 35.058827
License Name TARI ANDERSON

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.**

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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?

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. 1-4

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

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

. 0

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

. 0

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. 25-29

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. 0

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. 0

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

. 0

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1. Enter the first zip code:

. 45230

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

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

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. . . . . 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}*

NPI number

1. Please enter your current NPI number

. 1326142829

DEA number

1. Please enter your DEA number

. . . . . BA3027388

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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.