




April 9, 2015

CERTIFICATION OF RECORD

To whom it may concern:

Re: **Katherine C. Whitehouse, D.O.**

I, James C. Sparks, Lead Enforcement Analyst and Official Custodian of Records of the Osteopathic Medical Board of California, do hereby certify that **Katherine C. Whitehouse, D.O.**, was issued an osteopathic physician's and surgeon's license number **20A13651** by the Osteopathic Medical Board of California on October 17, 2014. Said license is current and expires on June 30, 2016



JAMES C. SPARKS
Lead Enforcement Analyst
Osteopathic Medical Board of CA

Section 162 of the Business and Professions Code: The certificate of the officer in charge of the records of any board in the department that any person was or was not on a specified date, or during a specified period of time, licensed, certified or registered under the provisions of law administered by the Board, or that the license, certificate or registration of any person was revoked or under suspension, shall be admitted in any court as prima facie evidence of the facts therein recited.

2000682
3458653

Department of Consumer Affairs
Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834
(916) 928-8390 Fax (916) 928-8392
www.dca.ca.gov/osteopathic



APPLICATION FOR OSTEOPATHIC PHYSICIAN'S AND SURGEON'S CERTIFICATE

Please read all instructions prior to completing this application. All questions on this application must be answered. In addition to this form, other essential application requirements must be completed.

FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Please type or print legibly. If space provided is insufficient, attach additional sheets. **3458653/1-4824/249.-**

1. NAME: Last: Whitehouse		First: Katherine	Middle: Carson
OTHER NAMES USED if any: Katherine Whitehouse		2. SOCIAL SECURITY NO: [REDACTED]	
3. DATE OF BIRTH: [REDACTED]	4. PLACE OF BIRTH: Newton, NJ, USA		5. SEX: Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>
6. ADDRESS: [REDACTED]			
MAILING ADDRESS if different:			
7. CONTACT INFORMATION FOR APPLICATION PROCESS:			8. Are you a US citizen? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Daytime Phone Number: [REDACTED]		E-Mail address: [REDACTED]	
9. PRE-OSTEOPATHIC COLLEGE(S)	ADDRESS	DATES OF ATTENDANCE	
University of Maryland	College Park, MD	1999-2003	
10. OSTEOPATHIC COLLEGE(S)	ADDRESS	DATES OF ATTENDANCE:	
University of Medicine & Dentistry of New Jersey (currently called Rowan University)	42 E Laurel Rd, Stratford, NJ 08084	2005-2009	
DATE OF DEGREE: 2009			
11. POSTGRADUATE TRAINING INTERNSHIP (AOA)	Hospital Name	Address	Type of Service
University of Connecticut		263 Farmington Avenue, Farmington, CT 06030-2947	OB/GYN
RESIDENCY/FELLOWSHIP:		Dates of Service	
Baylor College of Medicine: 1 Baylor Plaza, BCM610 Houston, TX 77030		2010-2013	
12. BOARD CERTIFIED: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	DATE CERTIFIED:	NAME OF CERTIFYING BOARD:	
13. LIST ALL WRITTEN EXAMINATIONS TAKEN e.g. NBOME, State Written Boards, USMLE, FLEX etc.			
STATE WHICH EXAMINATIONS AND WHERE TAKEN		DATE COMPLETED	
NBOME Step 1 (New Jersey)		6/14/2007	
NBOME Step 2 CE (New Jersey)		10/16/2008	
NBOME Step 2 PE (New Jersey)		12/15/2008	
NBOME Step 3 (Texas)		12/15/2012	
14. LIST ALL STATES IN WHICH YOU ARE NOW LICENSED OR HAVE EVER BEEN LICENSED TO PRACTICE OSTEOPATHIC MEDICINE			
STATE	DATE LICENSED	* HOW LICENSED	LICENSE NUMBER
Hawaii	6/2013-6/2016	National Boards	1519
15. Have you ever applied for but did not take the California Osteopathic Medical Board Examination? If Yes, when? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
16. Have you ever taken the California Osteopathic Medical Board Examination? If Yes, when? Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>			

FP TOWMC #10

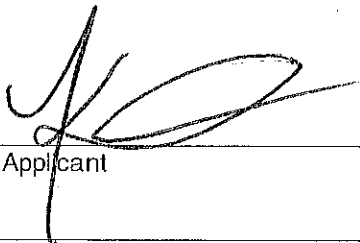
RECEIVED
2014 JUN 25 PM 2:22
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

17. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training? If Yes, attach explanation.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
18. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgment or arbitration award of over \$30,000.00?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
19. Has there ever been any peer group or professional association inquiry or action involving your practice or relationship with patients alleging unprofessional conduct, wrongdoing or negligence?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
20. Have you ever withdrawn an application from any hospital, public entity or licensing agency? If Yes, When?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
21. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
22. Have you ever had a medical or any healing art license restricted, suspended, revoked, disciplined or denied in any state?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
23. Have you ever been denied permission to practice medicine or any healing art in any state?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
24. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW: <input type="checkbox"/> A condition which required admission to an inpatient psychiatric treatment facility <input type="checkbox"/> Alcohol or chemical substance dependency or addiction <input type="checkbox"/> Emotional, mental or behavioral disorder <input type="checkbox"/> Other (explain) _____ FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
25. Have you ever been charged, convicted of, pled guilty or noia contendere to a misdemeanor or felony in any state? (Do not include traffic violations or citations resulting in fines of \$250 or less.) You must include all convictions, including those that have been set aside, and dismissed or expunged, or where a stay of execution has been issued.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
26. Is any criminal action related to the above now pending?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
27. Do you have a Drug Enforcement Administration (DEA) number?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
28. If yes, what is the DEA number and in what state was it issued? <u>FW3851739 - Hawaii</u>		
29. Has any DEA number ever been restricted, suspended or revoked?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, ATTACH DETAILED EXPLANATION AND SUPPORTING DOCUMENTS.

CERTIFICATION

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT.



Signature of Applicant

6/17/14

Date

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilized a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you."



INFORMATION COLLECTION AND ACCESS

Agency requesting information: Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834, (916) 928-8390.

All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Executive Director is the custodian of records.

APPLICANT DECLARATION/SIGNATURE and NOTARY

STATE OF Hawaii

COUNTY OF Honolulu

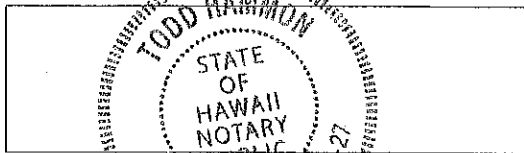
The applicant, Katherine Carson Whitehouse, [REDACTED], being first duly
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

sworn upon his/her oath deposes and says: that he/she is the person herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he/she is the lawful holder of the degree of Doctor of Osteopathic Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were produced without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Applicant further states that he/she authorizes all hospitals, institutions, or organizations, his/her references, agencies (local, state, federal or foreign), to release to the Osteopathic Medical Board of California or its successors, any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Board in connection with this application; or any further or future investigation by the Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of osteopathic medicine. He/she further authorizes the Osteopathic Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. He/she further acknowledges that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

SIGNATURE OF APPLICANT: [Signature]

Signed and sworn to before me this 18th day of June, 2014
(month) (year)

Notary Seal



[Signature]
 7006 Hammon
 Signature of Notary Public
 1319 Punahou St #824 Honolulu, HI 96826
 Address

My Commission expires 4/26/2017

Doc. Date: 6/18/2014
 # Pages: 3
 Doc. Description: Application for Osteopathic Physicians & Surgeon's Certificate
 X [Signature] 6/18/2014
 TODD HAMMON, Notary Public Date