

Cashman, Casandra Miller
Medical Doctor 41301099902
December 19, 2011

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Exam

APPLICATION FOR MEDICAL DOCTOR LICENSE
Authority: Public Act 360 of 1978, as amended

If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, DEA, 431 Howard Street, Detroit, MI 48226 (1-800-882-9539)

099900

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

License by Examination Fee: \$150.00 71-4301-01

Controlled Substance Fee: \$85.00 43-01 71-5315

053247

Board/Use Only
License Number <i>(San Info) 430157</i>
Controlled Substance License Number
Date of Licensure <i>1/12/12</i>

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

Legal First Name <i>Cassandra</i>	Legal Middle Name <i>Miller</i>	Legal Last Name <i>Cashman</i>
U.S. Social Security Number [Redacted]	Date of Birth [Redacted]	Daytime Phone Number <i>(502) 759 8027</i>
Street Address <i>29 Pine Valley Circle</i>	E-Mail Address <i>cassandra.cashman@yahoo.com</i>	
City <i>Ormond Beach</i>	State <i>FL</i>	Zip Code <i>32174</i>
All Previous Names and/or Birth Name Used (if applicable) <i>Cassandra Lynn Miller, Sydney-Cassandra Miller, Cashman, Sydney-Cassandra Miller</i>		
Have you ever held a health professional license in Michigan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Michigan Health Professional Permanent ID Number and Expiration Date	

Check the appropriate answer to each of the following questions. NOTE: Submit a detailed explanation for any YES answer you check on a separate sheet with your application.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

9. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privilege involuntarily modified? Yes No
10. Do you hold or have you ever held a permanent medical license in any state, U.S. Territory or Canadian Province? If yes, list the state(s) U.S. Territory or Province in which you hold or have held a medicine license, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. You must have each licensing agency verify licensure directly to this board office. (Attach additional sheets, if necessary) Yes No

State, U.S. Territory or Province	License Number	Date of Issue	How obtained (Endorsement or examination)
Florida	ME 107604		

Provide a complete chronological record of your educational preparation.
Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From To	Degree
see attached		

Provide a description of your professional medical experience.
Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice From To	Duties
Halifax Medical Center 303 N. Clyde Morris Blvd Daytona Beach, FL 32114	7/2009 - present	house officer

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant Chashman Date 12.15.11

Casandra Miller Cashman
Addendum for Michigan Medical license application regarding Educational Preparation

University of Louisville
School of Medicine
Abell Administration Center
323 E. Chestnut Street
Louisville, KY 40292

Doctor of Medicine
8/2005-5/2009

University of Kentucky
769 Woodland Avenue
Lexington, KY 40526

Postbaccalaureate studies (no degree)
6/2003-5/2004

Wells College
Route 90
Aurora, NY 13026

Bachelor of Arts
8/2000- 5/2003

Midway College
512 E. Stephens Street
Midway, KY 40347

No degree
1/2000-5/2000

Michigan Department of Licensing and Regulatory Affairs
Board of Medicine
 P.O. Box 30192
 Lansing, MI 48909
 (517) 335-0918
 www.michigan.gov/healthlicense

Page 2
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 CM

CERTIFICATION OF POSTGRADUATE TRAINING

Authority: Public Act 368 of 1970, as amended
 If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

SECTION I - APPLICANT INFORMATION

First Name Casandra	Middle Name Miller	Last Name Cashman
Social Security Number [REDACTED]	Date of Birth [REDACTED]	
Street Address 21 Pine Valley Circle		
City Ormond Beach	State FL	ZIP Code 32174
Daytime Telephone Number 386 673 3378	All Previous Names and/or Birth Names Used (if applicable) sydney-casandra miller cashman	

Signature of Applicant Cashman	Date 12-15-11
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name: Cassandra Miller Cashman

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital: Halifax Medical Center

Street Address of Hospital: 303 N. Clyde Morris Blvd

City, State and ZIP Code: Daytona Beach, FL 32114

I certify that Cassandra Miller Cashman a graduate of the University of Louisville medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 07/01/09 to 06/30/12 in the clinical area of Family Medicine.

On schedule to complete training on 06/30/12

Is this an active training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? Yes No

Edwin E. Prevatte

Signature of Director of Medical Education

12-15-11

Date of Signature

Edwin E. Prevatte, M.D.

Print or Type Name of Director of Medical Education

(SEAL)

If hospital has no seal, please indicate

NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.

Michigan Department of Licensing and Regulatory Affairs
Board of Medicine
 P.O. Box 30192
 Lansing, MI 48909
 (517) 335-0910
 www.michigan.gov/healthlicensing

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 DEC 27 2011
 DEPT. OF LRA

STUDENT AFFAIRS
 DEC 21 2011
 SCHOOL OF MEDICINE

**CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS
 LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR
 THE DOMINION OF CANADA**

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your legal name exactly as it appears on your application. For Section II, send this form to be completed by the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name <i>Cassandra</i>	Middle Name <i>Miller</i>	Last Name <i>Cashman</i>
Social Security Number [REDACTED]	Date of Birth [REDACTED]	Daytime Telephone Number <i>(502) 759-8027</i>
Street Address <i>29 Pine Valley Circle</i>		
City <i>Ormond Beach</i>	State <i>FL</i>	ZIP Code <i>32174</i>
All Previous Names and/or Birth Name Used (if applicable) <i>Cassandra Lynn Miller, Sydney-Cassandra Miller, Sydney-Cassandra Miller-Cashman</i>		
Date of Admission <i>8/2005</i>		Date of Graduation <i>5/2009</i>

Signature of Applicant <i>Cashman</i>	Date <i>12.8.11</i>
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name Cassandra Miller Cashman

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School	Office of Medical Student Affairs
Street Address of Medical School	School of Medicine University of Louisville
City, State and ZIP Code	Louisville, KY 40292

I certify that Cassandra Cashman (Applicant's Name) attended the
 medical school named above from 8/15/05 to 4/24/09
 (Month/Day/Year) (Month/Day/Year)
 and was/will be granted the degree of Doctor of Medicine on
5/9/2009
 (Month/Day/Year)

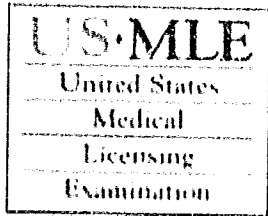
Sherril Gary
 Signature of Dean or Registrar

12/21/11
 Date of Signature

Sherril Gary, Sr. Academic Coordinator
 Print or Type Name of Dean or Registrar

(SEAL)

If school has no seal, please indicate



United States Medical Licensing Examination® (USMLE®) Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Eufless, TX 76039-3856 -- Telephone (817) 868-4041

Date : 12/14/2011

Recipient:

Michigan Board of Medicine
ATTN: Carole Hakala Engle, Licensing Director
611 W Ottawa
1st Floor
Lansing, MI 48933

Examinee: Casaman, Casandra
Alt Name(s): Cashman, Casandra Miller
Cashman, Sydney-Casandra Miller

Examinee ID#: 5-194-518-6
Date of Birth: [REDACTED]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
06/02/2007	Pass	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
10/24/2008	Pass	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

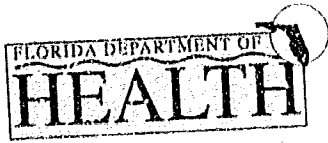
Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
09/16/2008	Pass	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
03/19/2010	Pass	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.



Rick Scott
Governor

H. Frank Farmer, Jr., MD, PhD, FACP
State Surgeon General

December 14, 2011

Michigan Board of Medicine
P O Box 30670
Lansing, MI 48909

RE: License Certification for Casandra Miller Cashman

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Medical Doctor
LICENSE NUMBER:	ME107804
ORIGINAL CERTIFICATION:	07/23/2010
EXPIRATION DATE:	01/31/2014
CURRENT STATUS OF LICENSE:	CLEAR, ACTIVE
AGENCY ACTION:	None

This license information was last updated on: 12/13/2011

To expedite the verification process, the above format is the standard format for all health care practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595, option 5.



Division of Medical Quality Assurance * Licensing and Auditing Services Unit
4052 Bald Cypress Way, Bin C-10 * Tallahassee, FL 32399-3260
Fax: (850) 245-4791
Visit us online at floridashealth.com