AMA-APP-SENT 6/2/95

STATE MEDICAL BOARD OF OHIO

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

Lisa Keder, M.D.

REQUEST FOR APPLICATION FORMS
(MEDICAL OR OSTEOPATHIC)

PLEASE TYPE OR PRINT CLEARLY

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

	LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
NAME:	Keder	Lisa	Margret	

	STREET & NUMBER
ADDRESS:	5464 Wilkins Avenue

CITY	STATE	ZIP CODE	COUNTRY
Pittsburgh,	Pennsylvania	15217	U.S.A.

	AREA CODE & NUMBER		AREA CODE & NUMBER
TELEPHONE: BUSINESS:	(412) 641-1440	HOME:	(412) 683-4615

	MO/DAY/YR		CITY	STATE	COUNTRY
BIRTHDATE:	3 /21/ 60	BIRTHPLACE:	Richland,	Washington	U.S.A.

MEDICAL OR OSTEOPATHIC EDUCATION

	SCHOOL NAME
MEDICAL SCHOOL OF GRADUATION:	Ohio State University College of Medicine

STREET ADDRESS	
Meiling Hall	Ohio State University

CITY	STATE		COUNTRY
Columbus,	Ohio	43210	U.S.A.

DATES ATTENDED: FROM:	MO/DAY/YR	TO:	MO/DAY/YR
	9 / / 85		6 / / 89

DEGREE RECEIVED:		DATE RECEIVED:	MO/DAY/YR
	M.D.		6 /9 /89

OTHER MEDICAL SCHOOLS ATTENDED: (IF NONE, ENTER "NONE")

SCHOOL NAME
None

STREET ADDRESS

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

SCHOOL NAME

STREET ADDRESS

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM: (IF NONE, ENTER "NONE")

HOSPITAL OR INSTITUTION
None

AFFILIATED WITH:

NAME OF MEDICAL SCHOOL | CITY | STATE | ZIP CODE

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

QUALIFYING EXAM TAKEN: DATE TAKEN: MO/DAY/YR / /

CONTINUED ⇨

GRADUATE MEDICAL EDUCATION

List ALL graduate medical education (internship, residency, or clinical fellowship), undertaken in the U.S. or Canada. If additional space is needed, please attach an extra sheet. (If none, enter "NONE")

A.

month/year	Hospital, University or Other:	Position & Department	Level of Training (check one only)
7 / 89	University of Pittsburgh Health	Intern, Obstetrics Gynecology	☒ 1st year
TO	Complete Street Address: Magee Womens Hopital, 300 Halket Street (Street & Number)		☐ 2nd year
6 / 90	Pittsburgh, PA 15213 (City / State/Country / Zip)		☐ 3rd year or above
month/year			

B.

month/year	Hospital, University or Other:	Position & Department	Level of Training (check one only)
7 / 90	University of Pittsburgh	Resident, Obstetrics Gynecology	☐ 1st year
TO	Complete Street Address: see above (Street & Number)		☒ 2nd year
6 / 91	City / State/Country / Zip		☐ 3rd year or above
month/year			

C.

month/year	Hospital, University or Other:	Position & Department	Level of Training (check one only)
7 / 91	University of Pittsburgh	Resident, Obstetrics Gynecology	☐ 1st year
TO	Complete Street Address: (Street & Number)		☐ 2nd year
6 / 92	City / State/Country / Zip		☒ 3rd year or above
month/year			

D.

month/year	Hospital, University or Other:	Position & Department	Level of Training (check one only)
7 / 92	University of Pittsburgh	Resident Obstetrics Gynecology	☐ 1st year
TO	Complete Street Address: (Street & Number)		☐ 2nd year
6 / 93	City / State/Country / Zip		☒ 3rd year or above
month/year			

OVER ⇨

WRITTEN EXAMINATIONS TAKEN

List each and every written (FLEX, National Boards, USMLE or State Board) exam taken whether in Ohio or any other state, territory or province. Use one section for each exam portion taken. If additional space is needed, please attach an extra sheet.

STATE	DATE TAKEN	TYPE OF EXAM	SECTIONS TAKEN	FINAL RESULTS
Ohio	(MO/YR) 5 / 87	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☒ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☒ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☒ PASS ☐ FAIL
Ohio	(MO/YR) 4 / 89	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☒ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☒ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☒ PASS ☐ FAIL
Pennsylvania	(MO/YR) 6 / 90	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☒ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☒ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☒ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL

STATE MEDICAL BOARD OF OHIO
'95 MAY 10 PM 12:

CONTINUED ⇨

GRADUATE MEDICAL EDUCATION

List ALL graduate medical education (internship, residency, or clinical fellowship), undertaken in the U.S. or Canada. If additional space is needed, please attach an extra sheet. (If none, enter "NONE")

		Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	Level of Training (check one only)
E. A.	9 93 month/year TO 8 94 month/year	University of Pittsburgh see above	Fellow, Obstetrics Gynecology	☐ 1st year ☐ 2nd year ☒ 3rd year or above
F. B.	9 94 month/year TO 8 95 month/year	University of Pittsburgh	Fellow, Obstetrics Gynecology	☐ 1st year ☐ 2nd year ☒ 3rd year or above
C.	month/year TO month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	Level of Training (check one only) ☐ 1st year ☐ 2nd year ☐ 3rd year or above
D.	month/year TO month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	Level of Training (check one only) ☐ 1st year ☐ 2nd year ☐ 3rd year or above

STATE MEDICAL BOARD OHIO 95 MAY 30 PM 1:

OVER ⇨

LICENSES IN THE UNITED STATES & CANADA

List ALL states/provinces **whether the license is current or not** in which you are or have been licensed (except temporary, educational permits, etc.) to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number, date of issuance, and the basis of licensure (e.g., FLEX, endorsement of diplomate status, USMLE, endorsement of another state license, state board exam, etc.) If additional space is needed, please attach an extra sheet. (If none, enter "NONE")

STATE/PROVINCE	ISSUE DATE	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
✓ Pennsylvania	(MO/YR) 9 / 91	MD045468L	(✓ ONE ONLY) ☒ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ______	(✓ ONE ONLY) ☒ YES ☐ NO Expiration date: 12/31/96
	(MO/YR) /		(✓ ONE ONLY) ☐ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ______	(✓ ONE ONLY) ☐ YES ☐ NO Expiration date: ______
	(MO/YR) /		(✓ ONE ONLY) ☐ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ______	(✓ ONE ONLY) ☐ YES ☐ NO Expiration date: ______
	(MO/YR) /		(✓ ONE ONLY) ☐ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ______	(✓ ONE ONLY) ☐ YES ☐ NO Expiration date: ______
	(MO/YR) /		(✓ ONE ONLY) ☐ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ______	(✓ ONE ONLY) ☐ YES ☐ NO Expiration date: ______

AMERICAN MEDICAL ASSOCIATION
NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE

The American Medical Association (AMA) has implemented a National Physician Credentials Verification Service (NPCVS), which for a fee will verify a physician's possessive credentials.

Are you currently a member of the AMA's NPCVS? ☐ YES ☒ NO

For further information contact the AMA at the address below:

AMERICAN MEDICAL ASSOCIATION
NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE
515 N. STATE STREET, 4TH FLOOR
CHICAGO, IL 60610
(312)464-5000

OVER ⇨

ADDITIONAL ELIGIBILITY INFORMATION

ANSWER ALL QUESTIONS	YES	NO
Are you a licentiate of the Medical Council of Canada?	☐	☒
Are you applying to take Step 3 of the USMLE in Ohio? ☐ June or ☐ December	☐	☒
Do you have a valid ECFMG Certificate? Number: _____ Date Issued: / (MO/YR)	☐	☒
Have you held a current and unrestricted license in the US for five years or more? (Refer to the TSE section in the Eligibility Packet for more information)	☐	☒
Have you been actively practicing medicine and surgery or osteopathic medicine and surgery (approved training included) in the US for five years or more? (Refer to the TSE section in the Eligibility Packet for more information)	☒	☐
Have you applied for or taken the Test of Spoken English (TSE)* of the Educational Testing Service (ETS)? Date Taken: / (MO/YR) Score: _____	☐	☒
Have you achieved a score of at least two hundred thirty (230) on TSE* of the ETS? Date Taken: / (MO/YR) Score: _____	☐ N/A	☐

*[THE TOEFL, ECFMG EXAM, ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (TSE).]

CERTIFICATION

I hereby certify that I am the person referred to in the foregoing Request for Application forms and that the statements herein are strictly true in every respect.

√ _____
Signature of Applicant

5 / 26 / 95
Date

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

University of Pittsburgh
SCHOOL OF MEDICINE
Department of Obstetrics, Gynecology and Reproductive Sciences

May 25, 1995

Penny McKenzie
Chief, Licensure
State Medical Board of Ohio
77 South High Street
17th Floor
Columbus, OH 43266-0315

Dear Ms. McKenzie:

Enclosed please fine my request for application and preliminary education forms for medical licensure. The application can be mailed to me at the address below.

Thank you.

Sincerely,

Lisa M. Keder, M.D.

MAGEE-WOMENS HOSPITAL, 300 HALKET STREET, PITTSBURGH, PA 15213-3180
(412) 641-4220 FAX: (412) 641-1133

65

MEDICINE OR OSTEOPATHIC PRELIMINARY EDUCATION FORM

NAME:

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
Keder	Lisa	Margret	

HIGH SCHOOL OR EQUIVALENT:

SCHOOL NAME	CITY	STATE	COUNTRY
Bradford Area High School	Bradford	Pennsylvania	U.S.A.

DATES ATTENDED: FROM: MO/DAY/YR 9 / / 75 TO: MO/DAY/YR 6 / / 78

UNDERGRADUATE COLLEGE OR EQUIVALENT:

SCHOOL NAME	CITY	STATE	COUNTRY
Oberlin College	Oberlin	Ohio	U.S.A.

DATES ATTENDED: FROM: MO/DAY/YR 9 / / 78 TO: MO/DAY/YR 5 / / 82 DEGREE RECEIVED: B.A. ✓

RJB

SCHOOL NAME	CITY	STATE	COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / / DEGREE RECEIVED:

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:

SCHOOL NAME	CITY	STATE	COUNTRY
Ohio State University	Columbus,	Ohio	U.S.A.

DATES ATTENDED: FROM: MO/DAY/YR 9 / / 85 TO: MO/DAY/YR 6 / / 89 DEGREE RECEIVED: M.D.

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: 87559 DATE ISSUED: AUG 0 9 1995

STATE MEDICAL BOARD OF OHIO
95 MAY 31 AM 12:13

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

Ray 2. Bumgarner
Entrance Examiner

Thomas E. Butler M.D.
Secretary

#1927
#325.00
7/20/95

STATE MEDICAL BOARD OF OHIO

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

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: [redacted]

2. Full Name (Use no initials):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
Keder	Lisa	Margret	

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

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
Keder	Lisa	Margret	

4. Maiden Name Or Other Names Used (If none, enter "NONE"):

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

5. Current Address:

STREET & NUMBER			
5464 Wilkins Avenue			
CITY	**STATE**	**ZIP CODE**	**COUNTRY**
Pittsburgh	PA	15217	U.S.A.

6. Physical Description:

HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	IDENTIFYING MARKS
5'2"	110 lbs	Brown	Green	none

7. Sex: ☐ MALE ☒ FEMALE For statistics only (optional)

8. City In Ohio Where You Plan To Practice:

CITY	OR	COUNTY
Columbus		

PLANS OF PRACTICE: Ohio State Univ. Dept. of OB/GYN

9. Specialty Boards (U.S.A., Canada and foreign countries):

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
American Board of Obstetrics and Gynecology	☐	☒	1993 - Active Candidate	
	☐	☐		
	☐	☐		

STATE MEDICAL BOARD OF OHIO RECEIVED JUL 17 PM 3

FOR OFFICE USE ONLY ☐ 34 ☐ 35 ☐ Examination ☐ Endorsement

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

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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 "looking for residency program" or "vacation", as well as your permanent address for this period. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. **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.

A.

month/year	Hospital, University or Other: / Complete Street Address / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
7 89	Univ. of Pittsburgh - Magee - Womens Hosp.	Internship Residency in Obstetrics and Gynecology	100
TO	300 Halket St.		% Admin.
6 93	Pittsburgh, PA 15213		

B.

month/year	Hospital, University or Other: / Complete Street Address / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
7 93	N/A	Maternity Leave	
TO			% Admin.
8 93			

C.

month/year	Hospital, University or Other: / Complete Street Address / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
9 93	Univ. of Pittsburgh	Fellow in Contraception Obstetrics and Gynecology	75%
TO	Magee - Womens Hospital 300 Halket St.		% Admin. 25%
present	Pittsburgh, PA 15213		

D.

month/year	Hospital, University or Other: / Complete Street Address / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
	N/A		
TO			% Admin.

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

E.

month/year TO month/year	Hospital, University or Other: Complete Street Address Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

F.

month/year TO month/year	Hospital, University or Other: Complete Street Address Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

G.

month/year TO month/year	Hospital, University or Other: Complete Street Address Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

H.

month/year TO month/year	Hospital, University or Other: Complete Street Address Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

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 physician 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 A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Margaret Watt-Morse, a licensed and practicing physician in the state of
(recommending physician)

Pennsylvania, affirm that Lisa M. Keder
(state of residence) (applicant)

has been known to me personally for 5 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: Excellent

*His/her relationship with patients is: Excellent

*I rate his/her ability to work well with peers and medical staff as: Excellent

*His/her command of the English language is: Excellent

*Additional comments: A great physician

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

Margaret L. Watt-Morse
Signature of Recommending Physician
(name stamps not acceptable)

MARGARET L. WATT-MORSE
Name of Recommending Physician
(please type or print clearly)

(412) 641-4734
Telephone Number
(include area code)

University of Pittsburgh
Magee Womens Hospital
300 Halket St. Pittsburgh, PA 15213
Address of Recommending Physician
(include city, state and zip code)

PA MD-043646-E
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 1st day of August, 1995.

Susan M. Kostilnik
Notary Public Signature

Notarial Seal
Susan M. Kostilnik, Notary Public
Pittsburgh, Allegheny County
My Commission Expires Nov. 2, 1998
Member, Pennsylvania Association of Notaries

Date Commission Expires

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icant
aken
hs

Jm Kyle
Signature of Applicant

Date Photo Taken: 6/95
Mo./Yr

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

Revised 02/09/94

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

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 physician 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 A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Marvin Bolin, a licensed and practicing physician in the state of
(recommending physician)

Pennsylvania, affirm that Lisa Keder
(state of residence) (applicant)

has been known to me personally for 6 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: SUPERIOR

*His/her relationship with patients is: Excellent

*I rate his/her ability to work well with peers and medical staff as: Excellent

*His/her command of the English language is: outstanding

*Additional comments: Superb physician

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

Marvin C Rulin
Signature of Recommending Physician
(name stamps not acceptable)

MARVIN C RULIN
Name of Recommending Physician
(please type or print clearly)

(412) 641 4454
Telephone Number
(include area code)

MAGEE WOMENS HOSPITAL.
PITTSBURGH PA 15213
Address of Recommending Physician
(include city, state and zip code)

Pennsylvania MD 005785 E
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 18th day of July, 1995.

Susan M. Kostilnik
Notary Public Signature

Notarial Seal
Susan M. Kostilnik, Notary Public
Pittsburgh, Allegheny County
My Commission Expires Nov. 2, 1998
Member, Pennsylvania Association of Notaries

Date Commission Expires

Staple
COL
here
withi
(bl

J.M Kyle
Signature of Applicant

Date Photo Taken: 6/95
Mo./Yr

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

Revised 02/09/94

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P.O. BOX 2649
HARRISBURG, PA 17105-2649

LISA MARGARET KEDER
5464 WILKINS AVENUE
PITTSBURGH PA 15217

JULY 20, 1995

STATE BOARD OF MEDICINE

LISA MARGARET KEDER

MEDICAL PHYSICIAN AND SURGEON

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON IS LICENSED IN THE COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF STATE, STATE BOARD OF MEDICINE.

THE RECORDS OF THE PENNSYLVANIA STATE BOARD OF MEDICINE SHOW NO DEROGATORY INFORMATION AGAINST THIS LICENSE.

ORIGINAL LICENSURE DATE: SEPTEMBER 06, 1991
EXPIRATION DATE: DECEMBER 31, 1996
LICENSE NUMBER: MD-045468-L

Dorothy Childress

Dorothy Childress
Commissioner

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 4 - VERIFICATION OF LICENSE

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

TO BE COMPLETED BY APPLICANT

Keder, Lisa Margret	MD0454681	10/15/94
Name in full (last, first, middle, suffix)	License number	Issue date (mo/day/yr)
5464 Wilkins Ave., Pittsburgh, PA 15217	3/21/60	Ohio State University
Complete address (street, city, state & zip)	Date of birth	Medical school of graduation

I HEREBY AUTHORIZE THE LICENSING AGENCY OF THE STATE OR PROVINCE OF Pennsylvania TO FURNISH THE INFORMATION BELOW TO THE STATE MEDICAL BOARD OF OHIO.

[signature]	6/16/95
Signature of applicant	Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province	Name of Licensee
License Number	Issue Date

Is License current: ❑ Yes ❑ No If not, please explain: _____

OVER ⇨

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?

❑ YES ❑ NO ❑ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state?

❑ YES ❑ NO ❑ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?

❑ YES ❑ NO ❑ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

_____
Signature

_____
Title

_____
Date

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

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

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.

(Please place a ✔ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
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 or resign privileges at 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 reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or 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 graduate medical education?	☐	☑
5.	Have you ever transferred from one graduate medical education to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑

OVER ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

		YES	NO
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by, or have you ever been notified of, any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Are you now or have you ever been, addicted to or excessively used alcohol, drugs, or other substances which may cause physical or psychological dependence, or impairment of the ability to practice?	☐	☑
14.	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 an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
15.	Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
16.	Have you ever been denied, or surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑

CONTINUED ⇨

ADDITIONAL INFORMATION-MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

	YES	NO
17. Have you ever been convicted or found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	☐	☑
18. Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☑
19. 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? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
20. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
21. Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, include Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
22. Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

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 considered as incomplete.

ss STATE OF OHIO

COUNTY OF Franklin

I, Lisa M. Keder, hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor 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 or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is not refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

(NOTARY SEAL)

Lisa M. Keder
Signature of Applicant

Subscribed and sworn to before me this 14th day of July 1995.

NOTARIAL SEAL STATE OF OHIO

CYNTHIA J. SMITHSON
NOTARY PUBLIC, STATE OF OHIO
MY COMMISSION EXPIRES APRIL 8, 1998

Cynthia J. Smithson
Notary Public Signature

4-8-98
Date Commission Expires

Revised 05/26/92

FOR BOARD USE ONLY

NAME: Keder, Lisa M

CERTIFICATE NO.: 69022

DATE ISSUED: Aug 24, 1995

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE OR OSTEOPATHIC MEDICINE

FILED: June 2, 1995

FEE: _____

DETERMINATION:

BOARD ACTION:

CYNTHIA L. SMITHSON
NOTARY PUBLIC, STATE OF OHIO
MY COMMISSION EXPIRES AUG. 8, 1998

The Ohio State University

hereby confers upon

Elisa Margaret Reuter

the degree of

Doctor of Medicine

together with all the rights, privileges and honors appertaining thereto in consideration of the satisfactory completion of the curriculum prescribed in this University and by the authority of the Board of Trustees.

In Testimony Whereof, the seal of the University and the signatures as authorized by the Board of Trustees are hereunto affixed.

Ohio College of Medicine

Given at Columbus on the ninth day of June, in the year of our Lord nineteen hundred eighty-nine and of the University the one hundred twenty-fifth.

President of the University

Secretary of the Board of Trustees

Chairman of the Board of Trustees

THE OHIO STATE UNIVERSITY · 1870 ·

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: **The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.**

Diplomate Name: Lisa Margret Keder, MD

Date of Birth: 03/21/1960

Certification Date: 07/01/1990

Certificate #: 371375

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME	Jun	620	380		640	615	525	555	545	560	770
PART I	1987	87	75	PASS	89	88	82	84	83	84	98

					Med	Surg	Ob/Gyn	PM/PH	Ped	Psych
NBME	Apr	660	290		570	575	740	655	635	630
PART II	1989	87	75	PASS	84	85	92	88	87	87

NBME	Mar	635	290	
PART III	1990	86	75	PASS

DATE: 07/27/1995

SEE OTHER SIDE FOR SCORE INFORMATION

OH1059

This *Endorsement of Certification* may include scores for Step 1, Step 2, or Step 3 of the United States Medical Licensing Examination™ (USMLE™). The USMLE, established by the Federation of State Medical Boards (FSMB) and the NBME, is a single, uniform medical licensure examination system comprised of three Step examinations. USMLE replaced both the Federation Licensing Examination (FLEX) and the NBME Parts I, II and III. The NBME accepts passing scores on Part I or Step 1, **plus** Part II or Step 2, **plus** Part III or Step 3 as meeting the examination requirements for its certification program. Physicians who have passed at least one NBME Part in combination with one or two USMLE Steps will be certified and endorsed to medical licensing authorities by the NBME. Scores for physicians who pass Steps 1, 2 and 3 will be reported by the FSMB.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

USMLE Step 1, Step 2, and Step 3

The complete USMLE examination history is given. A total test score is reported on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All NBME Part III Examinations

The most recent total test score is reported. This score is on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Two-Digit Scores

For all examinations, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

EXPLANATION OF COMMENTS

For USMLE Steps, this document is annotated to reflect special circumstances regarding the score report.

If you wish to obtain further information about individual examinees who have notations under "Comments," please write the NBME Department of Licensing Examination Services, Examinee Records Unit.

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

Incomplete - The examinee sat for some but not all of the scheduled test books. **No score is reported.**

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. To determine the exact nature of the irregular behavior, the examinee's full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat at (215) 590-9600.

Score Not Available - Score not available pending further review and/or analysis.

Testing Accommodations - Following review and approval of a request from the examinee, testing accommodations were provided in the administration of the examination.

STATE MEDICAL BOARD OF OHIO

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

DATE 8/10/95

Dear Doctor:

Dr. Lisa M. Keder who is/was Fellow-OB/GYN 9/93-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 application for licensure. **This form must be completed and returned to our office within two (2) weeks to ensure processing of the doctor's application.** Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 3 years

(2) What is/was your supervisory capacity? Chairman Dept OB/Gyn

(3) At what hospital? Magee - Women's Hospital

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

(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) Excellent

(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,

Mindy Booth

Mindy Booth
Licensure Assistant

STATE MEDICAL BOARD OF OHIO
95 AUG 21 AM 10:37

R L Sweet MD

Signature of Doctor, please type or print name legibly beneath

Richard L Sweet, MD

Chair Dept OB Gyn

Position

Telephone No. 412 641-4212 (Include Area Code)

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION

MAIL TO HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that my graduate medical education be certified. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Keder, Lisa M. — Name in full (last, first, middle, suffix)

3/21/60 — Date of birth (mo/day/yr)

5464 Wilkins Avenue Pittsburgh PA 15217 — Complete address (street, city, state & zip)

Ohio State University — Medical school of graduation

I hereby authorize University of Pittsburgh / Magee-Womens Hospital
Hospital or training institution

to furnish the following information concerning my graduate medical education to the State Medical Board of Ohio.

Lisa M. Keder — Signature of applicant

6/16/95 — Date

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Excellent

His/her relationship with patients is: Excellent

I rate his/her ability to work well with peers and medical staff as: Excellent

His/her command of the English language is: Excellent

Additional comments: _____

STATE MEDICAL BOARD OF OHIO AUG 7 AM 11:40

OVER ⇨

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION
MEDICINE OR OSTEOPATHIC MEDICINE

This certifies that LISA M. KEDER, M.D. has successfully completed
(name of applicant)

not less than 48 months of graduate medical education through the:
- ☐ 1st year level
- ☐ 2nd year level
- ☒ 3rd year level or above

as a(n):
- ☐ intern
- ☒ resident
- ☐ clinical fellow

in OBSTETRICS/GYNECOLOGY
(department)

at MAGEE-WOMENS HOSPITAL 300 HALKET ST., PITTSBURGH, PA. 15213
(name of hospital) (complete street address of hospital)

from 06/24/89 to 06/23/93.
beginning (mo/day/yr) ending (mo/day/yr)

It is further certified that the above named:
- ☐ will be awarded a certificate on} _____ mo/day/yr
- ☒ was awarded a certificate on} 06/23/93 mo/day/yr
- ☐ was not awarded a certificate
  please explain: _____

and that the training:
- ☒ was accredited by ACGME/AOA, Royal College of Physicians and Surgeons, College of Family Physicians or National Joint Commission
- ☐ was not accredited by ACGME/AOA, Royal College of Physicians and Surgeons, College of Family Physicians or National Joint Commission

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

(SEAL OF HOSPITAL)*

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

William R. Crombleholme, M.D.
Signature of Medical Director or Program Director
(Original signature only, names stamps will not be accepted)

WILLIAM R. CROMBLEHOLME, M.D.
Name (please print or type)

Susan M. Kostilnik 8/08/95

8/7/95
Date

Notarial Seal
Susan M. Kostilnik, Notary Public
Pittsburgh, Allegheny County
My Commission Expires Nov. 2, 1998
Member, Pennsylvania Association of Notaries

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

Revised 02/09/94

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 _____ 3/8/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-9022	$250.00	05/01/96

LISA MARGRET KEDER,M.D.
STONERIDGE OB/GYN
4053 W DUBLIN-GRANVILLE RD
DUBLIN OH 43017

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

PLEASE SEE DATA ON LABEL

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: 093506902 2 11" 1"00000 25000 1"

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.

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?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

383 00197 043096 05589 MC# 741893 935069022
AX BATCH # DATE AMOUNT BATCHDATE 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 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 _____ 3/4/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-9022-K	$275.00	05/01/98

LISA MARGRET KEDER,M.D.
STONERIDGE OB/GYN
4053 W DUBLIN-GRANVILLE RD
DUBLIN OH 43017

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☒ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 093506902 2" "00000 27500"

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 :

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)

935069022
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 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 4/17/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-9022-K	$305.00	07/01/2000

LISA MARGRET KEDER,M.D.
STONERIDGE OB/GYN
4053 W DUBLIN-GRANVILLE RD
DUBLIN OH 43017

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.

74 S. Stanwood Rd
STREET
STREET
Bexley OH 43209
CITY STATE ZIP CODE
Franklin
COUNTY

:96969696 21: 093506902 21" :"0000030500":

MUST BE ENTERED AT EACH RENEWAL

4053 W Dublin-Granville Rd
Street
Street
Dublin OH 43017
City State Zip Code
Franklin
County

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

YES NO ☑ 1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?

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

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

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

YES NO ☑ 5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?

YES NO ☑ 6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances?

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

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 2000 - 2002 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] 4/18/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-9022-K	$305.00	07/01/02	10/01/02

LISA MARGRET KEDER,M.D.
4053 W DUBLIN GRANVILLE ROAD
DUBLIN OH 43017

0935069022 30500

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.

74 S STANWOOD RD
STREET
STREET
BEXLEY OH 43209
CITY STATE ZIP CODE
FRANKLIN
COUNTY

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.

4053 W DUBLIN-GRANVILLE RD.
Street
Street
DUBLIN OH 43017
City State Zip Code
FRANKLIN
County

050320027117000
1 0161 081
069022
1 SE 000030500

REQUIRED:
[redacted]
SOCIAL SECURITY NUMBER

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 DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION IN COMPLIANCE WITH O.R.C. 4731.281 AND O.A.C. 4731-10, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X M Keder 5/4/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 069022	305.00	7/1/2004	10/1/2004

Dr. LISA MARGRET KEDER
74 S STANWOOD RD
BEXLEY OH 43209

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG

☒ **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.

74 S Stanwood Rd
STREET
STREET
Bexley OH 43209
CITY STATE ZIP CODE
Franklin
COUNTY

SELECT ONE ADDRESS FOR MAILINGS FROM THE BOARD.
☐ RESIDENCE ☒ PRINICIPAL PRACTICE ADDRESS

0003647649 30500 35ZZ 069022

IN OHIO :

2 [redacted] 0133 067

SE 00000500

	YES	NO
1.) Have you been found guilty of, or pled guilty or contest to, or received treatment or intervention lieu of conviction of, a felo or misdemeanor?	☐	☒
2.) Have you been addicted or dependent upon alcohol any chemical substance; been treated for, or be diagnosed as suffering fro drug or alcohol depender or abuse? **You may answ "NO" to this question if y have successfully complet** treatment at, or are currentl enrolled in, a program approv by this Board and have adhered to all statutory requiremer during and subsequent to treatment. You must answer "YE if you have ever relapsed. Any questions concerning progra approval or concerning this question can be directed to t board offices.	☐	☒
3.) Have any malpractice awards or settlemer been paid by you or on your behalf for ac occurring in any state other than Ohio?	☐	☒
4.) Has any board, bureau, department, agency, other body, including those in Ohio, **other th this board**, filed any charges, allegations complaints against you?	☐	☒
5.) Have you surrendered, or consented limitation of, or to suspension, reprimand probation concerning, a license to practice a healthcare profession or state or feder privileges to prescribe controlled substances any jurisdiction? You may answer "NO" to th question if the only such surrender or conse was given to this board.	☐	☒
6.) Have you had any clinical privileges or oth similar institutional authority suspended, restrict or revoked for reasons **other than failure maintain records on a timely basis or to atte staff meetings?**	☐	☒

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL

☐ *Check this Box if you have NO principal Practice address.*

4053 W Dublin Granville Rd.
Street
Street
Dublin OH 43017
City State Zip Code
Franklin
County

REQUIRED:
[redacted]
SOCIAL SECURITY NUMBER

Date Posted:

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

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

License Information

License Number	35.069022
License Name	LISA KEDER
Email Address	

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   ..... NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   ..... NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints

against you?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Holly France-Kremin, CNP; Susan Sexton-Bluestone, CNP; Alicia Shanks, CNP; Ayla Wolfe, CNP; Maryls Baumann, CNP

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

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

Date Posted: 4/16/2008 2:03:21 PM

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

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

Address Information

CREDENTIAL MAIL ADDRESS

OSU Dept. of Ob/gyn
5th Floor, Means Hall
1654 Upham Dr.
Columbus, OH 43210
Franklin County
614-293-9899
lisa.keder@osumc.edu

License Information

License Number	35.069022
License Name	LISA KEDER
Email Address	keder.1@osu.edu

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

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

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Holly France-Kremin NP-04862; Susan Sextone-Bluestone NP-01695; Johanna Taylor NP-04039; Dana Buechner Np-03906; Alicia Shanks Np-08609; Marlys Baumann NP-07922; Jennifer Dush NP-09078

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: 4/23/2010 12:08:21 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	4053 W DUBLIN-GRANVILLE RD DUBLIN, OH 43017 Franklin County (614) 764-2262

License Information

License Number	35.069022
License Name	LISA KEDER

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   ..... NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Holly France-Kremin CNP, Susie Bluestone CNP, Angela Wright CNP,Julia Wilson, CNP, Alicia Shanks CNP, Johanna Taylor CNP, Marlys Baumann CNP, Dana Buechner CNP

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

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

Date Posted: 4/5/2012 3:30:46 PM

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

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

Address Information

CREDENTIAL MAIL ADDRESS

OSU Dept. of Ob/gyn
5th Floor, Means Hall
1654 Upham Dr.
Columbus, OH 43210
Franklin County
614-293-4929
lisa.keder@osumc.edu

License Information

License Number 35.069022
License Name LISA KEDER

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Kathryn Martin, CNP; Susan Blueston, CNP, Stephanie Phillips, CNP; Holly France-Kremins, CNP; Johanna Taylor; CNP; Alicia Shanks, NP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 40-44

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

. 5-9

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.

. 1-4

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).

. 25-29

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

. 15-19

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

. 1-4

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 43017

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. 43210

4. Enter the second county:

. . . . . Franklin

5. Enter the third zip code:

. 43213

6. Enter the third county:

. . . . . Franklin

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 4053 W Dublin Granville Rd, Dublin Ohio 43017; 456 W 9th Ave. Columbus, OH 43210; 3325 E. Main St, Columbus, OH 43213

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

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?

. . . . . 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}*

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: 4/22/2014 10:15:55 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	35.069022
License Name	LISA KEDER

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts

occurring in any state other than Ohio?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Laurie Macleod, CNM; Elizabeth Austin, CNM

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 40-44

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.)

. 15-19

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

. 1-4

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).

. 20-24

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

. 20-24

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:

. 43210

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. 43017

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. 43212

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

. . . . . 10+

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?

. . . . . 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

. 1730122557

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . bk2940662

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.