OHIO STATE MEDICAL BOARD

MAY 2 4 2001

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

FOR BOARD USE ONLY
FEE: $75.00
BK: 34 **PG:** 39 **LN:** 9
DATE: 6-8-01 **PMT:** 24594

APPLICATION FOR TRAINING CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

PERSONAL INFORMATION

Your social security number is required to facilitate reporting to the Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under Ohio's child support enforcement law (§2301.373.O.R.C.) It may also be used for investigation/enforcement purposes.

Social Security Number: [redacted]

Full Name (Use no Initials):	Last (Surname)	First	Middle	Suffix (Jr., II)
	Wood	Sharon	Ann	

Maiden Name Or Other Names Used (If none, enter "NONE"):	Last (Surname)	First	Middle	Suffix (Jr., II)

Physicians Address:

Number & Street			
3011 Montclair Ave.			
City	**State**	**Zip Code**	**Country**
Cincinnati	OH	45211	USA

Birth Date: MO/DAY/YR 11/27/74 Birth Place: City Crystal Falls State MI Country USA

Gender: ☐ Male ☒ Female For statistics only *(optional)*

TRAINING PROGRAM INFORMATION

Training Program Address (Hospital where you will be starting your training):

Hospital & Department		
University of Cincinnati Family Medicine		
Number & Street		
2446 Kipling Ave.		
City	**State**	**Zip Code**
Cincinnati	OH	45239-6695

Training Program Telephone: Phone No.: Area Code & Number (513) 853-4350 FAX No.: Area Code & Number (513) 541-3902

Dates of Training: Beginning Date: MO/DAY/YR 6/21/01 Ending Date: MO/DAY/YR 6/20/04

OVER ⇨

MEDICAL OR OSTEOPATHIC EDUCATION

Medical or Osteopathic School of Graduation:

School Name: Michigan State University College of Human Medicine
Street Address: Life Sciences Bldg. Service Rd. MSU
City: E. Lansing State: MI Country: USA

Dated Attended: From: MO/YR 8/97 To: MO/YR 5/01

Degree Received: Medical Doctor Date Received: MO/DAY/YR 5/12/01

Other Medical or Osteopathic Schools Attended (If None, enter "NONE"):

School Name: None
Street Address:
City: State: Country:

Dates Attended: From: MO/YR / To: MO/YR /

Reason degree not received at this school:

FIFTH PATHWAY PROGRAM

Fifth Pathway Program (If None, enter "NONE"):

Hospital or Institution: None
Name of Medical School:
City: State:

Dates Attended: From: MO/YR / To: MO/YR /

ECFMG CERTIFICATE

To be completed by International medical school graduates only:

Do you have a valid ECFMG certificate? ☐ YES ☐ NO

Number:_____ Date Issued: MO/DAY/YR / / Expires: MO/DAY/YR / /

CONTINUED ⇨

J-1 and H-1B VISA

To be completed by International medical school graduates only:

Are you currently applying for a J-1 or an H-1B Visa? ☐ YES ☐ NO

PHYSICAL DESCRIPTION

Staple a recent (taken within the last six months) passport-type **COLOR** photograph of applicant in the space provided below. Black and white photographs cannot be accepted.

STAPLE

(Photo taken within ar Black t

Date Photo Taken: 3/01
mo/yr

PHYSICAL DESCRIPTION:

Height 5'4"

Weight 120

Hair Color brown

Eye Color brown

Identifying Marks mole above (L) eyebrow

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, including temporary, educational permits, limited licenses, etc., to practice medicine and surgery or osteopathic medicine and surgery. Indicate license number, date of issuance and the type of license. If additional space is needed, attach an extra sheet. **(If none, enter "none")**

STATE/PROVINCE	ISSUE DATE	LICENSE #	TYPE OF LICENSE	LICENSE CURRENT
	MO/YR		✓ ONLY ONE	✓ ONLY ONE
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ (please specify)	☐ YES ☐ NO Expiration Date: _____
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ (please specify)	☐ YES ☐ NO Expiration Date: _____
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ (please specify)	☐ YES ☐ NO Expiration Date: _____

CONTINUED ⇨

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES

List ALL activities in chronological order from the date of medical school graduation to the PRESENT time, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", as well as your permanent address.* 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. **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, please attach separate sheets.

☐ **Check here if you are a new graduate (within 3 months). You DO NOT need to complete this form.**

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

OVER ⇨

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

CONTINUED ⇨

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
ADDITIONAL INFORMATION

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(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, residency, or graduate medical education program?	☐	☒
5.	Have you ever transferred from one graduate medical education program 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?	☐	☒
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?	☐	☒

OVER ⇨

		YES	NO
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 any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	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?	☐	☒
14.	Have you ever been denied, or have you ever 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?	☐	☒
15.	Have you ever been convicted or found guilty of a violation of any law, regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☒
16	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)?	☐	☒
17.	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.	☐	☒
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☒
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including 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?	☐	☒
20.	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?	☐	☒

CONTINUED ⇨

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain.	☐	☑
22.	a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
	b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment.

* *

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☑
	a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	☐	☑

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

		YES	NO
	b) Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	☐	☑

OVER ⇨

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☑
a)	Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	☐	☑

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

		YES	NO
b)	Are the limitations or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? if yes, please explain.	☐	☑

* *

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
a)	If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances. If yes, please explain.	☐	☑

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MAY 24 2001

State Medical Board of Ohio

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

CERTIFICATION OF HOSPITAL

TO BE COMPLETED BY APPLICANT

Name of Applicant: Wood (Last) Sharon (First) Ann (Middle) ____ (Suffix (Jr., II))

TO BE COMPLETED BY TRAINING PROGRAM

Name of Training Program: University of Cincinnati Family Med.

Training Program Address: 234 Goodman Street (Street Address)

Cincinnati (City) OH (State) 45267-0796 (Zip Code)

Type of Program (*check only one*): ☑ Intern ☐ Resident ☐ Clinical Fellow

Specialty Code (*see reverse side*): FP

CERTIFICATION DATES - Indicate the month, day and year for both the beginning and ending dates in which the training certificate is to be issued. THE DATES ARE NOT TO EXCEED ONE YEAR. If the application is received prior to the date of the appointment, the appointment date will be used. If the application is received after the appointment date, or is not completed until after the appointment date, the completion date will be the date the certificate will become effective.

Dates (*not to exceed one year*): Beginning Date: MO/DAY/YR 06 / 21 / 01 Ending Date: MO/DAY/YR 06 / 30 / 02

I hereby certify that I have checked the credentials of the above applicant, that the statements, as completed, are true to the best of my knowledge and he/she is of good moral character. I further certify that he/she will limit his/her practice and training within the physical confines of the hospital, or facilities for which the training certificate to practice is sought and that he/she will practice only under the supervision of the attending medical staff of such hospital or facility for which the training certificate to practice is granted. I hereby recommend that the above applicant be granted the certificate herein applied for.

Philip Deller — Original Signature of Medical Director or Program Director

5/24/01 — Date

HOSPITAL SEAL (If hospital has no seal, indicate and have form notarized)

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

Signed before me on 5/24/01 by Dr Philip Deller

Sharon F Mullen

SHARON F. MULLEN
Notary Public, State of Ohio
My Commission Expires April 6, 2005

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SPECIALTY CODES

CODE	DESCRIPTION
AS	Abdominal Surgery
ADM	Addiction Medicine
ADP	Addiction Psychiatry
AMI	Adolescent Medicine (Internal Medicine)
ADL	Adolescent Medicine (Pediatrics)
OAR	Adult Reconstructive Orthopedics
AM	Aerospace Medicine
A	Allergy
AI	Allergy & Immunology
ALI	Clinical Laboratory Immunology (All & Imm)
PTH	Anatomic/Clinical Pathology
ATP	Anatomic Pathology
AN	Anesthesiology
BBK	Blood Banking/Transfusion Medicine
ICE	Clinical Cardiac Electrophysiology
CTS	Cardiothoracic Surgery
CD	Cardiovascular Diseases
PCH	Chemical Pathology
CHP	Child and Adolescent Psychiatry
CHN	Child Neurology
CBG	Clinical Biochemical Genetics
CCG	Clinical Cytogenetics
CG	Clinical Genetics
DDL	Clinical & Lab. Dermatological Immunology
ILI	Clinical & Lab. Immunology (Int. Med.)
PLI	Clinical & Lab. Immunology (Pediatrics)
CMG	Clinical Molecular Genetics
CN	Clinical Neurophysiology
CLP	Clinical Pathology
PA	Clinical Pharmacology
CRS	Colon & Rectal Surgery
CCA	Critical Care Medicine (Anesthesiology)
CCM	Critical Care Medicine (Internal Medicine)
NCC	Critical Care Medicine (Neurological Surg.)
OCC	Critical Care Medicine(OB-GYN)
PCP	Cytopathology
D	Dermatology
DMP	Dermatopathology (Pathology)
DMD	Dermatopathology (Dermatology)
DS	Dermatologic Surgery
DIA	Diabetes
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology, Diabetes & Metabolism
EP	Epidemiology
FPS	Facial Plastic Surgery
FP	Family Practice
FOP	Forensic Pathology
PFP	Forensic Psychiatry
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GS	General Surgery

CODE	DESCRIPTION
FPG	Geriatric Medicine (Family Practice)
IMG	Geriatric Medicine (Internal Medicine)
PYG	Geriatric Psychiatry
GYN	Gynecology
GO	Gynecological Oncology
HS	Hand Surgery (Orthopedic Surgery)
HNS	Head & Neck Surgery
HEM	Hematology (Internal Medicine)
HMP	Hematology (Pathology)
HO	Hematology/Oncology
HEP	Hepatology
IG	Immunology
PIP	Immunopathology
ID	Infectious Diseases
IM	Internal Medicine
MPD	Internal Medicine/Pediatrics
LM	Legal Medicine
MFM	Maternal & Fetal Medicine
MXR	Maxillofacial Radiology
MG	Medical Genetics
MDM	Medical Management
MM	Medical Microbiology
ON	Medical Oncology
ETX	Medical Toxicology (Emer. Med)
PDT	Medical Toxicology (Pediatrics)
PTX	Medical Toxicology (Prevent. Med.)
OMO	Musculoskeletal Oncology
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
N	Neurology
NRN	Neurology/Diag. Radiology/Neuroradiology
NS	Neurological Surgery
NP	Neuropathology
RNR	Neuroradiology
NM	Nuclear Medicine
NR	Nuclear Radiology
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics & Gynecology
OM	Occupational Medicine
OPH	Ophthalmology
ORS	Orthopedic Surgery
OSS	Orthopedic Surgery of the Spine
OTR	Orthopedic Trauma
OFA	Foot & Ankle, Orthopedics
OMM	Osteopathic Manipulative Medicine
OTO	Otolaryngology
OT	Otology/Neurotology
APM	Pain Management (Anesthesiology)
PDM	Pain Medicine
PLM	Palliative Medicine
PDA	Pediatric Allergy
PDC	Pediatric Cardiology

CODE	DESCRIPTION
CCP	Pediatric Critical Care Medicine
PE	Pediatric Emergency Medicine (Emer. Med)
PEM	Pediatric Emergency Medicine (Pediatrics)
PDE	Pediatric Endocrinology
PG	Pediatric Gastroenterology
PHO	Pediatric Hematology/Oncology
PDI	Pediatric Infectious Disease
PN	Pediatric Nephrology
PO	Pediatric Ophthalmology
OP	Pediatric Orthopedics
PDO	Pediatric Otolaryngology
PP	Pediatric Pathology
PDP	Pediatric Pulmonology
PDR	Pediatric Radiology
PPR	Pediatric Rheumatology
NSP	Pediatric Surgery (Neurology)
PDS	Pediatric Surgery (Surgery)
UP	Pediatric Urology
PD	Pediatrics
PM	Physical Medicine & Rehabilitation
PS	Plastic Surgery
PRO	Proctology
P	Psychiatry
PYA	Psychoanalysis
MPH	Public Health & General Preventive Med.
PCC	Pulmonary Critical Care Medicine
PUD	Pulmonary Disease
RO	Radiation Oncology
RP	Radiological Physics
R	Radiology
RIP	Radioisotopic Pathology
REN	Reproductive Endocrinology
RHU	Rheumatology
SP	Selective Pathology
SM	Sleep Medicine
SCI	Spinal Cord Injury
ESM	Sports Medicine (Emergency Medicine)
FSM	Sports Medicine (Family Practice)
ISM	Sports Medicine (Internal Medicine)
OSM	Sports Medicine (Orthopedic Surgery)
PSM	Sports Medicine (Pediatrics)
HSP	Hand Surgery (Plastic Surgery)
HSS	Surgery of the Hand (Surgery)
CCS	Surgical Critical Care (Surgery)
SO	Surgical Oncology
TRS	Trauma Surgery
TTS	Transplant Surgery
UM	Undersea Medicine
U	Urology
VIR	Vascular & Interventional Radiology
VS	Vascular Surgery
OS	Other (i.e., specialty other than those listed)
US	Unspecified

State Medical Board of Ohio

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

VERIFICATION OF MEDICAL EDUCATION
TO BE COMPLETED BY LCME OR AOA ACCREDITED SCHOOLS ONLY

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by any medical or osteopathic schools I have attended. Please complete this form and return it directly to the State Medical Board of Ohio at the above address.

TO BE COMPLETED BY APPLICANT

Name: Wood (last) Sharon (first) Ann (middle) _____ (suffix (Jr., II))

Name of Medical/Osteopathic School: Michigan State University College of Human Med.

I hereby authorize the above name medical/osteopathic school to furnish the information below to the State Medical Board of Ohio.

Sharon A. Wood — Signature of Applicant — 4/3/01 — Date

TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that _____ (Last / First / Middle / Suffix (Jr., II))

attended our medical/osteopathic school from _____ (mo/day/yr) to _____ (mo/day/yr)

This individual (*check one*):

- ☐ was awarded the degree of _____ on _____ (mo/day/yr)
- ☐ was not awarded a degree (please attach an explanation)

I, certify that the above information is an accurate account of the above named individual's official records maintained and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL

(If your institution does not have an official seal, please indicate and have form notarized)

_____ Signature

_____ Title

_____ Date

UPON COMPLETION RETURN DIRECTLY TO:
(DO NOT RETURN TO APPLICANT)

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

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICIND
AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release 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: Hamilton

I, Sharon A. Wood, hereby certify under oath that I am the person named in this application for a training certificate 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 training certificate 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 training certificate 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 a training certificate 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 I must limit my activities under the certificate to the programs of the hospitals or facilities for which the training certificate is issued; and that I may train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program.

I further understand that issuance of a training certificate in the State of 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.

Sharon A. Wood
Signature of Applicant

Subscribed and sworn to before me this 17 day of April 200 1.

Sharon F Mullen
Signature of Notary Public

(NOTARY SEAL)

SHARON F. MULLEN
Notary Public, State of Ohio
My Commission Expires April 6, 2005
Date Commission Expires

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

10/15/01

Sharon A. Wood
c/o University Hospitals
Family Practice
2446 Kipling Avenue
Cincinnati, Ohio 45329

APPLICATION RECEIVED: 6/8/01
ACKNOWLEDGMENT LETTER EXPIRES : 10/29/01

Dear Doctor:

Please be advised that your application for a training certificate in the State of Ohio was received by the Board on the above date. Your application was reviewed and found to be incomplete and you were sent notification. As of this date we have not received the requested information.

If a training certificate has not been issued to you by the expiration date listed above, you must cease your participation in the training program as of that date.

Enclosed is an incomplete letter. If you are planning on completing the application for a training certificate, you must submit/complete the missing information.

The Ohio Administrative Code provides that the Board may abandon an application if you fail to complete the application process within six months of initial application filing. Submitted fees will not be refundable or transferable.

Sincerely,

Gina Bouldware
Gina Bouldware
Licensure Examiner

01

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

OHIO STATE MEDICAL B
OCT 2 2 2001

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

VERIFICATION OF MEDICAL EDUCATION
TO BE COMPLETED BY LCME OR AOA ACCREDITED SCHOOLS ONLY

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by any medical or osteopathic schools I have attended. Please complete this form and return it directly to the State Medical Board of Ohio at the above address.

TO BE COMPLETED BY APPLICANT

Name: Wood (last) Sharon (first) A (middle) (suffix (Jr., II))

Name of Medical/Osteopathic School: College of Human Medicine - Mich. State Univ.

I hereby authorize the above name medical/osteopathic school to furnish the information below to the State Medical Board of Ohio.

Sharon A. Wood — Signature of Applicant

9/27/01 — Date

TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that Wood (Last) Sharon (First) Ann (Middle) (Suffix (Jr., II))

attended our medical/osteopathic school from August 25, 1997 (mo/day/yr) to April 27, 2001 (mo/day/yr)

This individual (*check one*):

☒ was awarded the degree of Doctor of Medicine on May 4, 2001 (mo/day/yr)

☐ was not awarded a degree (please attach an explanation)

I, certify that the above information is an accurate account of the above named individual's official records maintained and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL

(If your institution does not have an official seal, please indicate and have form notarized)

Michelle Nyquist — Signature

Michelle Nyquist

College Records Officer — Title

October 18, 2001 — Date

UPON COMPLETION RETURN DIRECTLY TO:
(DO NOT RETURN TO APPLICANT)

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

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43215-6127 • (614) 466-3934
Website : www.state.oh.us/med/

SHARON ANN WOOD,
C/O UNIV CINCI C.O.M. - FAM PRAC
231 ALBERT SABIN WAY ML#504
CINCINNATI OH 45267-0504

10/26/2001

NUMBER : 57-00-5257
HOSPITAL : UNIV OF CINTI HOSP/MED CTR-CINTI
INTERN FAMILY PRACTICE

DATES : 06/21/2001 - 06/20/2002

Dear Doctor :

This is to notify you that the above training certificate number has been issued to you in order for you to participate in the training program during the dates indicated above.

You are entitled to perform such acts as may be prescribed by or incidental to the internship, residency, or clinical fellowship program, but are not otherwise entitled to engage in the practice of medicine and surgery or osteopathic medicine and surgery in this state. You must limit your activities to the programs of the hospitals or facilities for which the training certificate is issued. You must train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program. Failure to abide by these limitations could result in the revocation of this certificate or criminal prosecution.

A training certificate shall be valid for one year, but may at the discretion of the Board be renewed annually for a maximim of five years. Renewal applications are mailed approximately April 1st for those who initiated their training on July 1st. Others will receive their renewal application accordingly.

Be sure to notify the Board, in writing, of any change in address within thirty days of the change. If you change programs before the end of the training year you must immediately notify the Board.

Sincerely,

Penny E. Grubb
Chief, Licensure

State Medical Board of Ohio

77 S. High St., 17th Floor ∘ Columbus, OH 43215-6127 ∘ (614) 466-3934 ∘ Website: www.state.oh.us/med/

OCT 11 2002

FOR BOARD USE ONLY
BK:_____ PG:_____ LN:_____
DATE: 10/16/02 FEE: $335.00 PMT: 0611

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY 13754-3542

☐ Check here if you wish to apply for a Telemedicine certificate

IDENTIFICATION

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.) It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760. or 4762., O.R.C. or as otherwise required by state or federal law.

U.S. Social Security Number	[redacted]			
Full Name (Use no initials)	Last (Surname): Wood	First: Sharon	Middle: Ann	Suffix (Jr., II):
Name (As you prefer it inscribed on your Ohio license)	Last (Surname): Wood	First: Sharon	Middle: Ann	Suffix (Jr., II):
Maiden Name or Other Names Used (If none, enter "NONE")	Last (Surname):	First:	Middle:	Suffix (Jr., II):
Current Home Address IMPORTANT Notify the Board office immediately in writing of any change in address	Number and Street: 3326 Renfro Ave	Apt.:		
	City: Cincinnati	State: OH	Zip Code: 45211	Country: USA
Telephone Number	Business: Area Code & Number (513) 230-0752	Home: Area Code & Number (513) 481-1545		
Birth Date	month/day/year 11/27/74	**Birth Place** City: Crystal Falls	State: MI	Country: USA
Physical Description	Height: 5' 4"	Weight: 120 lbs	Hair Color: Brown	Eye Color: Brown
	Identifying marks: mole above (L) eyebrow			
Gender	☐ Male ☑ Female	For statistics only (optional)		

Are you or will you be in an accredited training program in Ohio? ☑ Yes ☐ No
If yes, please identify name of training program and location:

Univ Cincinnati Family Practice, Cincinnati, OH Starting Date: 7/1/01
Name of Hospital/Training Program Location month/day/year

OVER ⇨

WRITTEN EXAMINATION

OCT 11 2002

Indicate which licensing examination(s) you have passed:

- ☐ National Boards (MD or DO)
- ☐ FLEX (Pre-1985)
- ☐ FLEX Components 1 & 2
- ☐ State Board exam:_____ (State & Date Taken (mo/yr))
- ☒ USMLE Steps 1, 2, 3
- ☐ LMCC
- ☐ Other: explain:_____

LICENSES IN THE UNITED STATES AND CANADA

List ALL states/provinces in which you hold or have held a license to practice medicine and surgery or osteopathic medicine and surgery, including a temporary license, training certificate, educational permit, or other license or certificate, ***whether the license is current or not***. If additional space is needed, attach an extra sheet. (If none, enter "N/A"). A Form 2, Verification of License, must be sent to each state listed.

STATE/PROVINCE	ISSUE DATE (MO/YR)	LICENSE NO.	LICENSE CURRENT YES	LICENSE CURRENT NO	EXPIRE(S)
Ohio	6/01	57.00-5257	☒	☐	6/03
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

SPECIALTY BOARDS

NAME OF SPECIALTY BOARD (If none, enter "N/A")	YEAR CERTIFIED	COUNTRY

CONTINUED ⇨

FEDERATION CREDENTIALS VERIFICATION SERVICE

OCT 11 2002

Ohio requires verification of your core credentials directly through the Federation Credentials Verification Service (FCVS).

Have you completed and forwarded the FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) application packet to FCVS? ☑ YES ☐ NO

If yes, date forwarded: 10/7/02 FCVS Packet ID Number (if known): _____

ECFMG CERTIFICATE
(International Medical School Graduates only)

ECFMG Number		Date Issued		Expiration Date	

TEST OF SPOKEN ENGLISH
(International Medical School Graduates only)

THE TOEFL, TWE, ECFMG'S ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 40 (230 if taken prior to 7/95) on the Educational Testing Services Test of Spoken English (TSE), regardless of citizenship or country of birth, unless you meet one of the following:

	YES	NO
Have you completed two years of undergraduate college work in the United States?	☐	☐
Have you held a current medical license in the United States AND have you been actively practicing medicine in the United States for the last five years?	☐	☐
Have you been participating in a graduate medical education program and since that time held an unrestricted license and actively practiced medicine in the United States for the last five years?	☐	☐
Have you completed a Fifth Pathway program?	☐	☐
Have you passed the Clinical Skills Assessment examination given by ECFMG on or after July 1, 1998?	☐	☐

If you answered NO to all of the above questions you must take the TSE. Refer to the application instructions for contacting the Educational Testing Service. The Board cannot waive this requirement.

OCT 11 2002

RESUME OF ACTIVITIES - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order beginning with medical school graduation to the PRESENT time, using MONTH and YEAR. *For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", as well as your permanent address.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked 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, please attach separate sheets.

From (Month/Year)	To (Month/Year)	Hospital, University or Other / Complete Street Address / City / State/Country / Zip Code	Position & Department	% Clinical	% Admin.
7/01	present	Mercy Franciscan Mt. Airy 2446 Kipling Ave Cincinnati OH 45239	Resident Physician	100	
8/01	9/01	VA medical Center 3200 Vine St Cincinnati OH 45219	Resident Physician - ICU	100	
10/01	10/02	University of Cincinnati Hospital 234 Goodman Ave. Cincinnati OH 45219	Resident Physician - ER	100	
2/01	present	Cincinnati Childrens Hospital 333 Burnet Ave Cincinnati OH 45229	Resident physician	100	
/	/				

OVER ⇨

OCT 11 2002

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. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(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, residency, or graduate medical education program?	☐	☑
5.	Have you ever transferred from one graduate medical education program 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?	☐	☑
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?	☐	☑

OVER ⇨

		YES	NO
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 any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	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?	☐	☑
14.	Have you ever been denied or have you ever 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?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☑
16	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)?	☐	☑
17.	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.	☐	☑
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including 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?	☐	☑
20.	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?	☐	☑

CONTINUED ⇨

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	☐	☑
22.	a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
	b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
	If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		

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For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **You may answer "NO" to this question if** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.	☐	☑
	a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?	☐	☑
	If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		
	b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☑

OVER ⇨

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☑
	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☑

OCT 11 2002

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.	☐	☐

State Medical Board of Ohio

77 S. High St., 17th Floor ◦ Columbus, OH 43215-6127 ◦ (614) 466-3934 ◦ Website: www.state.oh.us/med/

FORM 1 - CERTIFICATE OF RECOMMENDATION MEDICINE OR OSTEOPATHIC MEDICINE

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known 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 by the recommending physician. 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 ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, JEFFERY E HECK (recommending physician, print name), a licensed and practicing physician in the state of OHIO (state of residence),

affirm that SHARON WOOD (applicant, print name) has been known to me personally for 1+ 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 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: ___

I hereby recommend the applicar ... e medicine in the State of Ohio.

Jeffery E. Heck, M.D., Professor & Director
Univ Cincinnati Department of Family Med
International Health Program
2446 Kipling Avenue Ph: 513 853 4350
Cincinnati, OH 45239 USA

Address of Recommending Physician	Number & Stre	Telephone Number (include area code)	
	City		
Signature of Recommending Physician (name stamps not a...		State of Licensure & License Number	OH 35 04 5012

Signature of Applicant

Date Photo Taken: 9/02 (Mo/Yr)

Subscribed and sworn to before me this 4th day of October, 2002

Sharon F Mullen
Notary Public Signature

SHARON F. MULLEN
Notary Public, State of Ohio
My Commission Expires April 6, 2005
Date Commission Expires

NOTARY SEAL

State Medical Board of Ohio

77 S. High St., 17th Floor ◦ Columbus, OH 43215-6127 ◦ (614) 466-3934 ◦ Website: www.state.oh.us/med/

FORM 1 - CERTIFICATE OF RECOMMENDATION MEDICINE OR OSTEOPATHIC MEDICINE

OCT 11 2002

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known 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 by the recommending physician. 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 ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Philip M Diller (recommending physician, print name), a licensed and practicing physician in the state of OH (state of residence)

affirm that Sharon A Wood (applicant, print name) has been known to me personally for 2+ 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 licensure:

- I rate his/her medical knowledge and technique as: yes
- His/her relationship with patients is: yes
- I rate his/her ability to work well with peers and medical staff as: yes
- His/her command of the English language is: yes
- Additional comments: excellent physician

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 2446 Kipling Ave City: Cincinnati State: OH Zip Code: 45239	Telephone Number (include area code)	513 8534350
Signature of Recommending Physician (name stamps not a	Phy. Dr	State of Licensure & License Number	OH 35 05 9852

Sharon F. Wood
Signature of Applicant

Date Photo Taken: 9 / 02
Mo/Yr

Subscribed and sworn to before me this 4th day of October, 20 02.

Sharon F Mullen
Notary Public Signature

SHARON F. MULLEN
Notary Public, State of Ohio
My Commission Expires April 6, 2005
Date Commission Expires

NOTARY SEAL

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Sharon Ann Wood**
SSN:	[redacted]
DOB:	**11/27/1974**
Recipient:	**State Medical Board of Ohio**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Sharon Ann Wood**	
Other Name Used:	**N/A**	
Gender:	**Female**	
Date of Birth:	**11/27/1974**	
Place of Birth:	**Crystal Falls, MI USA**	
SSN:	[redacted]	
Current Address:	**3326 Renfro Avenue** **Cincinnati, OH 45211**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**N/A**
	Fax:	**N/A**
	Home:	**513-481-1545**
	Other:	**513-230-0752**
Physical Description:	Height:	**5' 4"**
	Weight:	**120 lbs**
	Eye Color:	**Brown**
	Hair Color:	**Brown**
Physical Marks:	Description:	**Mole**
	Location:	**Above Left Eyebrow**

Premedical Education (Reported by physician. Not verified by FCVS)**:**

Institution:	**Michigan State University, East Lansing, MI 48824**
Dates of Attendance:	**08/1993 - 05/1997**
Degree Awarded:	**Bachelor of Science**

Medical Education:

Current, valid ECFMG	**N/A**
ECFMG Number:	**N/A**
Date Issued:	**N/A**
Medical School:	**Michigan State University College of Human Medicine** **Office of Academic Programs** **A254 Life Sciences Building** **East Lansing, MI 48824**
Dates of Attendance:	**08/26/1997 - 04/27/2001**
Graduation Date:	**05/04/2001**
Degree Awarded:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Post Graduate Medical Education:

Institution:	**University of Cincinnati Medical Center** **Department of Family Practice** **2446 Kipling Avenue** **Cincinnati, OH 45239**
Post Graduate Year:	**1**
Program Type:	**Internship**
Department:	**Family Practice**
Dates of Attendance:	**07/01/2001 - 06/30/2002**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**2**
Program Type:	**Residency**
Department:	**Family Practice**
Dates of Attendance:	**07/01/2002 - 06/30/2003**
Completion:	**To Be Completed On 06/30/2003**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Omission / Discrepancy Report

Physician Identification:

Name:	Sharon Ann Wood
DOB:	11/27/1974
SSN:	[redacted]
Packet ID:	27553
Request ID:	9824530

REPORT OF OMISSIONS

There are none identified.

REPORT OF DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant reports attendance at Michigan State Univ from 07/01/1997 to 06/01/2001. The institution reports attendance from 08/26/1997 to 04/27/2001.
Follow-Up:	Left to Recipient's discretion.

MISCELLANEOUS INFORMATION

There are none identified.

End of report for Sharon Ann Wood

Packet Id: 27553 Request Id: 9824530 Report Created By: BJD

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name:	**Wood, Sharon Ann**
Date of Birth:	**11/27/1974**
Medical School:	**023010 - Michigan State Univ**
Year of Graduation:	**2001**
Social Security Number:	[redacted]
ECFMG Number:	**N/A**

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

FEB 18 2003

DALE L. AUSTIN
DEPUTY EXECUTIVE VICE PRESIDENT
AND CHIEF OPERATING OFFICER

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, 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 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 aspect.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service 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 Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, 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 Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Sharon A. Wood

Applicant's Signature (must be signed in the presence of a notary)

Wood

Applicant's **Printed** Last Name

Sharon Ann

Applicant's **Printed** First Name, Middle Initial, and Suffix (e.g., Jr.)

10/1/02

Date of Signature (must correspond to date of notarization)

State of Ohio, County of Hamilton,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 1st day of October, 2002

Notary Public signature: Sharon F. Mullen

SHARON F. MULLEN
Notary Public, State of Ohio
~~My Commission Expires April 6, 2005~~

My commission expires: **Notary:**

The Physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the *signature of the applicant.*

Federation Credentials Verification Service

C-102 27947 MICHIGAN DEPARTMENT OF PUBLIC HEALTH 74 113316

CERTIFICATE OF LIVE BIRTH 121 –

LOCAL FILE NUMBER — BIRTH NUMBER

1. CHILD- NAME	FIRST: Sharon	MIDDLE: Ann	LAST: WOOD	2a. DATE OF BIRTH (MONTH, DAY, YEAR): November 27, 1974	2b. HOUR: 2:30 AM.
3. SEX: Female	4a. THIS BIRTH—SINGLE, TWIN, TRIPLET, ETC. (SPECIFY): Single	4b. IF NOT SINGLE BIRTH—BORN FIRST, SECOND, THIRD, ETC. (SPECIFY):		5a. COUNTY OF BIRTH: Iron	
5b. CITY, VILLAGE OR TOWNSHIP OF BIRTH: Crystal Falls	5c. INSIDE CITY LIMITS (SPECIFY YES OR NO): Yes	5d. HOSPITAL—NAME (IF NOT IN HOSPITAL, GIVE STREET AND NUMBER): Crystal Falls Community Hospital			
6a. MOTHER—MAIDEN NAME FIRST: Jennifer	MIDDLE: Ann	LAST: Wiltshire	6b. SOCIAL SECURITY NUMBER: 378-62-7302	6c. AGE (AT TIME OF THIS BIRTH): 27	6d. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): India
7a. RESIDENCE—STATE: Michigan	7b. COUNTY: Iron	7c. CITY, VILLAGE OR TOWNSHIP: Crystal Falls	7d. INSIDE CITY LIMITS (SPECIFY YES OR NO): Yes	7e. STREET AND NUMBER: 405 Forest Avenue	
8a. FATHER—NAME FIRST: Dean	MIDDLE: Ralph	LAST: Wood	8b. SOCIAL SECURITY NUMBER: [redacted]	8c. AGE (AT TIME OF THIS BIRTH): 27	8d. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): Michigan
9a. INFORMANT: Jennifer Wood				9b. RELATION TO CHILD: Mother	
10a. I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE. SIGNATURE: E R Addison		10b. DATE SIGNED (MONTH, DAY, YEAR): Nov. 29, 1974		10c. ATTENDANT—M.D., D.O., MIDWIFE, OTHER (SPECIFY): M.D.	
10d. CERTIFIER—NAME (TYPE OR PRINT): E. R. Addison		10e. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): 211 S. 4th, Crystal Falls, Mich. 49920			
11a. REGISTRAR—SIGNATURE: Rena Anderson				11b. DATE RECEIVED BY LOCAL REGISTRAR (MONTH / DAY / YEAR): 12 / 14 / 74	

I hereby certify that the above is a true and correct representation of the vital record facts on file with the Division for Vital Records, Michigan Department of Community Health.

Certified by:

Carol V. Getts

Carol V. Getts
State Registrar

Date Issued: September 30, 2002

SEAL
VERIFIED

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Michigan State University College of Human Medicine

Complete Address: A254 Life Sciences Bldg.

Street Address:

City: East Lansing **State:** MI **ZIP Code (Postal Code):** 48824

If name of institution was different when this individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: Baccalaureate Degree Required

Credential/degree presented by the applicant for admission to your medical school: Bachelor of Science

Enrollment and Participation: Our records indicate that Wood, Sharon A.
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 152 weeks of medical education on the following dates (mm/dd/yy):

From August / 25th / 1997 (Month / Date / Year) **To** April / 27th / 2001 (Month / Date / Year)

This individual (check one):

[X] was awarded the degree of Doctor of Medicine on May / 4th / 2001 (Month / Date / Year)

[ ] was NOT awarded a degree (please attach an explanation)

Certification: By my signature, I, Michelle Nyquist (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available, this form must be notarized. SEAL VERIFIED

Signature: Michelle A Nyquist

Title: College Records Officer

Date of Signature: November 14, 2002

Phone: (517) 353-5440x244 **Fax:** (517) 432-1051

Email: nyquistm@msu.edu

VERIFICATION OF MEDICAL EDUCAT. (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response **YES** ☐ **NO** ☒

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response **YES** ☐ **NO** ☒

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response **YES** ☐ **NO** ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

   _____

   _____

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response **YES** ☐ **NO** ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

   _____

   _____

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic imcompetence, disciplinary problems, or any other reason?
   Response **YES** ☐ **NO** ☒

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

   _____

   _____

MICHIGAN STATE
UNIVERSITY

November 1, 2000

Dear Program Director:

This letter is written on behalf of Sharon A. Wood, a Year IV student from the Kalamazoo Campus of the College of Human Medicine at Michigan State University, who is applying for a residency position at your institution. This letter is divided into four major sections: premedical, preclinical, clinical, and student summary.

Premedical Background

Prior to enrolling in the College of Human Medicine, Sharon earned a Bachelor of Science degree in Medical Technology from Michigan State University in 1997. She was on the Dean's List for four years, received the Outstanding Senior Award, and was a member of Golden Key National Honor Society. Sharon participated in a research experience in the Department of Food Science and Human Nutrition.

While an undergraduate, she was a board member and served as President of the Medical Technology Student Association; was active in the MSU band, as well as a local community band; and did volunteer work for the Lansing Area AIDS Network Holiday Gift Project. Sharon worked as a lab assistant in Vitamin A and gene toxicology, and was a care giver for the developmentally disabled.

Sharon was admitted to the College of Human Medicine in the Fall of 1997.

Preclinical Education

Sharon successfully completed the preclinical curriculum, comprised of Block I (traditional lecture/laboratory format) in the first year and Block II (problem based, small group format) in the second year. She received letters of commendation for academic excellence in Genetics, Pharmacology, Microbiology, Anatomy, Physiology, Radiology, and Biochemistry.

While a preclinical student, Sharon was active in volunteer work at several area clinics; and was a member of a number of student organizations, including the Family Medicine Interest Group, Medical Students for Choice, and the Health Care Reform Group.

COLLEGE OF
HUMAN MEDICINE
Office of the Assistant Dean
Kalamazoo Campus
Michigan State University
Kalamazoo Center for
Medical Studies
1000 Oakland Drive
Kalamazoo, Michigan
49008
Telephone: 616/337-4400
FAX: 616/337-4424

During Summer Semester of 1999, Sharon progressed to the Kalamazoo Campus of the College of Human Medicine (i.e., MSU/KCMS) to complete her clinical training.

Clinical Evaluation

Sharon has successfully completed all required clerkships taken to date (performance data follows). Prior to receiving her M.D. degree, she is scheduled to complete additional rotations in Dermatology, Advanced Medicine, Family Planning, Sports Medicine, and Senior Surgery at MSU/KCMS; Infectious Disease at the University of Washington; and Anesthesiology at Oregon Health Sciences University.

Representative comments (in clerkship chronological order) from her preceptors include the following:

> Clinical Medicine in the Community – This required four week introductory clerkship serves as a transitional experience between the classroom based and clinical settings. "Friendly, prompt, asks appropriate questions. Seems mature at this stage of her education." Clerkship Coordinator – "Sharon progressed very well during the clerkship. She was always well prepared. Final grade is 'Pass'."
>
> Core Competency Seminar Series – All Year III students must attend a weekly seminar which focuses on Basic Science, Cost/Value Decision-Making, Critical Analysis, Ethics, Minority Health, Occupational Medicine, and Palliative Care. Sharon successfully completed all course requirements and received a passing grade.
>
> Pediatric Clerkship – "A very good student. Very teachable." "Sharon was actively engaged in learning and tried to be involved with the patients assigned to her. Established good rapport and attentively worked on physical diagnostic skills. A pleasure to work with. Inquisitive. Asked well thought out questions, anxious to learn." "Knowledge base appropriate for level of training." Clerkship Coordinator – "Sharon was very comfortable in the clinical setting. A good effort overall. Final grade is 'Pass'."
>
> Family Practice Clerkship – "I found Sharon to be prompt and polite. She related well to patients and exhibited good knowledge and skills for her level of training." Clerkship Coordinator – "Sharon actively

participated in all aspects of the rotation. She did an excellent job with her write-ups. My overall assessment is rated 7 on a scale of 9. Final grade is 'Pass'."

Internal Medicine – "A very good student. Will make a great doctor." "Inquisitive, hardworking, and personable." "Sharon is a very good student and will make an excellent primary care physician." Clerkship Coordinator – "Ms. Wood clearly met all the requirements of the clerkship and receives a final grade of 'Pass'."

Surgery Clerkship – "Good fund of knowledge. Good attitude and enthusiasm. Skills appropriate to level of training. Good interaction with patients. Above average student with good potential." "Shows a true commitment to and interest in learning. She asks pertinent and appropriate questions. She shows a broad knowledge base and is thorough in following up on patient care plans and intervention." "An excellent student. Took initiative, improved data base throughout rotation and was able to transfer basic information into clinical practice." Clerkship Coordinator – "Bright and aggressive. Self motivated to learn and gain experience. Did a good job. Received honors for her clinical performance. Final grade is 'Pass'."

Obstetrics/Gynecology Clerkship – "Good student, good performance. Excellent background in science." "Very easy to work with. She communicates well." Clerkship Coordinator – "Sharon passed the written and oral exams without difficulty. She achieved an Honors performance in the clinical portion of the clerkship. Sharon's preceptors indicated that she performed very capably in the service. I am sure that she will make an excellent physician. Final grade is 'Pass'."

Psychiatry Clerkship – ***HONORS*** – "Excellent aptitude with empathy and self disclosure. Student is in top 10% for participation in partial hospitalization." Clerkship Coordinator – "Sharon did quite well . Two preceptors nominated her for honors. Her comprehensive case study was rated as outstanding, she scored at the honors level on the final written exam and receives a final grade for the clerkship of 'Honors'."

Student Summary

Sharon has done an excellent job throughout medical school. She received letters of commendation for superior performance in seven preclinical courses,

and an "Honors" grade in the Psychiatry Clerkship. Sharon's preceptors have consistently praised her knowledge base, clinical skills, and compassion. Sharon is enthusiastic, articulate, hardworking, reliable and appropriately confident. She possesses all of the qualities necessary to be a successful resident. Her performance during Year III indicates that she will be a real asset to any program.

During the past year, Sharon has done volunteer work at the MSU/KCMS Migrant Clinic (a clinic staffed by our medical students, residents and faculty). She also was chosen to serve as a member of the Kalamazoo Campus Student Information Group. As a member of this group she provided campus information and tours to Year I CHM students.

The College of Human Medicine at Michigan State University uses the following designations – Outstanding, Excellent, Very Good, Good, and Marginal – to describe our students. Sharon A. Wood is recommended to you as a ***VERY GOOD*** candidate for residency training.

Sincerely,

Robert Carter MD

Robert Carter M.D.
Assistant Dean and CEO

Wanda Dlipscomb PhD

Wanda D. Lipscomb, Ph.D.
Assistant Dean for Student Affairs and Services

RC/WDL
enclosure

MICHIGAN STATE UNIVERSITY
COLLEGE OF HUMAN MEDICINE
Dean's Letter Attachment

Overview
Michigan State University's College of Human Medicine is a four-year, community-oriented medical school with the resources of one of the nation's largest land-grant universities at its disposal. Since CHM's founding in the mid-1960's, it has maintained a pioneering role in problem-based, community-integrated medical education.

Reflecting this orientation, our curriculum is divided into three blocks. The preclinical portion of the curriculum is comprised of a traditional lecture/laboratory format in the first year (Block I) and a problem-based, small group learning format in the second year (Block II). The clinical portion of the curriculum is conducted within one of six community campuses – Flint, Grand Rapids, Kalamazoo, Lansing, Saginaw, or the Upper Peninsula. Students are assigned to one of these community campuses where they complete their clinical education. The College graduates approximately 100 students each year.

Academic Assessment
Our medical school uses a Pass/No Pass (P/N) grading system within Blocks I and II and an Honors/Pass/No Pass (H/P/N) grading system within Block III. Please note that the official MSU transcript does NOT list Honor grades received. This information is communicated to you via the Dean's letter.

Professionalism is routinely assessed during all four years of the curriculum. These assessments are incorporated into each student's grade. A Pass (P) grade therefore indicates that the student has mastered the academic content and has demonstrated professionalism throughout the class or clerkship. A No Pass (N) grade can occur for classic academic reasons or for reasons of unprofessional behavior.

A Conditional Pass (CP) is given when the instructor believes the student's deficiency is specific and remediable and does not warrant repeating the entire clerkship. The CP remains on the transcript, becoming a Conditional Pass (CP/P) upon successful remediation or a Conditional Pass/No Pass (CP/N) if remediation requirements are not met.

Superior performance is recognized through the use of letters of commendation during the preclinical years and by the designation of Honors within the required clinical clerkships. Achievement is also recognized through acceptance into Alpha Omega Alpha (AOA) honor society. Approximately 16% of each graduating class are awarded membership in AOA during their senior year.

United States Medical Licensing Examination (USMLE)
Students are required to pass Step I of the USMLE for promotion into the clinical portion of the curriculum, and to pass Step II as a graduation requirement.

Performance Designations
The Community Campuses are asked to summarize each student's overall performance and assign a rating based on set criteria. These criteria are summarized below. The percentage of students receiving these designations is also listed.

Outstanding: Given to outstanding students who have distinguished themselves both academically and professionally. Received Honors in four or more of our required clerkships, with no CP or N grades.

Excellent: Given to highly competitive students generally in the upper third of their class who have consistently excelled academically and professionally. Received Honors in two or more of our required clerkships, with not more than one CP grade and no N grades.

Very Good: Given to students who have performed competently and professionally and who we anticipate will continue to perform very well in postgraduate education. Passed all required clerkships, with no more than one CP and no N grades.

Good: Given to students who have had some academic or non-academic difficulty but who have successfully remediated the difficulties. We believe that students in this category will perform well in postgraduate training. Passed all required clerkships, with no more than two CP grades and no more than one N grade.

Marginal: Given to students who have had difficulties and who may continue to have similar problems in postgraduate training. Expected to fulfill all graduation requirements.

Class of 2001 Ratings	%	Class of 2000 Ratings	%
Outstanding	16%	Outstanding	14%
Excellent	23%	Excellent	16%
Very Good	51%	Very Good	64%
Good	9%	Good	5%
Marginal	1%	Marginal	1%

(10/20/00)

MICHIGAN STATE UNIVERSITY

OFFICIAL ACADEMIC TRANSCRIPT

WOOD, SHARON ANN

STUDENT ID: A21037521

COURSE	TITLE	CRS	GRADE	S R	H
	PREVIOUS/TRANSFER INSTITUTIONS				
CHIPPEWA HILLS HIGH SCHOOL	ATTENDED: 08/89 - 05/93				
REMUS MI					
UNDERGRADUATE CREDIT					
	COURSE INFORMATION				
FALL SEMESTER 1993	08/30/93 - 12/17/93				
ISS 210	SOCIETY AND THE INDIVIDUAL (D)	4			4.0
LBS 117	COLLEGE ALGEBRA & TRIGONOMETRY	3			4.0
LBS 164	INTRO PHYSICS & CHEMISTRY I	3			3.0
LBS 164L	INTRO PHYSICS LAB I	1			3.5
SPN 101	ELEMENTARY SPANISH I	4			4.0
CUM CREDITS : 15.0	CUM GPA : 3.7666				
SPRING SEMESTER 1994	01/12/94 - 05/06/94				
LBS 118	CALCULUS I	5			4.0
LBS 133	INTRO SCIENCE & TECH STUDIES	4			4.0
LBS 165	INTRO CHEMISTRY & PHYSICS I	4			3.5
LBS 165L	INTRO CHEMISTRY LAB I	1			4.0
MUS 116	CAMPUS BAND	1			4.0
CUM CREDITS : 30.0	CUM GPA : 3.8166				
SUMMER SEMESTER 1994	05/16/94 - 06/30/94				
ISS 325	WAR AND REVOLUTION (I)	4			4.0
PES 107E	TENNIS I	1			4.0
SUMMER SEMESTER 1994	07/06/94 - 08/19/94				
PSY 101	INTRODUCTORY PSYCHOLOGY	4			4.0
CUM CREDITS : 39.0	CUM GPA : 3.8589				
FALL SEMESTER 1994	08/29/94 - 12/16/94				
CEM 251	ORGANIC CHEMISTRY I	3			4.0
LBS 144	BIOLOGY I: ORGANISMAL BIOLOGY	4			4.0
LBS 266	INTRO CHEMISTRY & PHYSICS II	3			4.0
LBS 266L	INTRO CHEMISTRY LAB II	1			4.0
MT 212	FUNDAMENTALS OF LAB ANALYSIS	3			4.0
MT 213	APPLIC OF CLINICAL LAB PRIN	1			4.0
CUM CREDITS : 54.0	CUM GPA : 3.8981				
SPRING SEMESTER 1995	01/11/95 - 05/05/95				
CEM 252	ORGANIC CHEMISTRY II	3			4.0
LBS 145	BIOLOGY II CELL & MOLEC BIO	4			3.5
LBS 267	INTRO PHYSICS & CHEMISTRY II	3			3.5
LBS 267L	INTRO PHYSICS LAB II	1			3.5
PSL 250	INTRODUCTORY PHYSIOLOGY	4			4.0
CUM CREDITS : 69.0	CUM GPA : 3.8623				
FALL SEMESTER 1995	08/28/95 - 12/15/95				
BCH 401	BASIC BIOCHEMISTRY	4			4.0
LBS 239	TOP SCIENCE & TECH STUDIES	4			4.0
MT 422	HEMATOLOGY AND HEMOSTASIS	4			4.0
STT 231	STATISTICS FOR SCIENTISTS	3			4.0
CUM CREDITS : 84.0	CUM GPA : 3.8869				
SPRING SEMESTER 1996	01/10/96 - 05/03/96				
CEM 255	ORGANIC CHEMISTRY LABORATORY	2			4.0
MIC 301	INTRODUCTORY MICROBIOLOGY	3			4.0
MIC 302	INTRO MICROBIOLOGY LAB	1			3.5
MT 414	CLIN CHEM & BODY FLUID ANLY	4			4.0
MT 432	CLIN IMMUN & IMMUNOHEMATOLOGY	5			4.0
CUM CREDITS : 99.0	CUM GPA : 3.8989				
----------END OF COLUMN----------					
SUMMER SEMESTER 1996	05/13/96 - 06/27/96				
FSC 490	SPEC PROBLEMS FOOD SCIENCE	2			4.0
IAH 201	U.S. & THE WORLD (D)	4			3.5
CUM CREDITS : 105.0	CUM GPA : 3.8857				
FALL SEMESTER 1996	08/26/96 - 12/13/96				
FSC 490	SPEC PROBLEMS FOOD SCIENCE	2			4.0
LBS 355	PHILOSOPHY OF TECHNOLOGY	4			4.0
MIC 463	MEDICAL MICROBIOLOGY	3			4.0
MIC 464	DIAGNOSTIC MICROBIOLOGY LAB	1			4.0
MT 416	CLINICAL CHEMISTRY	4			4.0
CUM CREDITS : 119.0	CUM GPA : 3.8991				
SPRING SEMESTER 1997	01/08/97 - 05/02/97				
IAH 241A	MUSIC/SOCIETY MODERN WRLD (D)	4			4.0
LBS 125	INTRO C LANG WITH APPLICATIONS	3			4.0
MT 495	DIRECTED STUDY	2			4.0
ZOL 316	GENERAL PARASITOLOGY	3			4.0
CUM CREDITS : 131.0	CUM GPA : 3.9083				
BACHELOR OF SCIENCE	GRANTED: 05/02/97				
MAJOR:	LBS MEDICAL TECHNOLOGY				
COLLEGE:	NATURAL SCIENCE				
	WITH HIGH HONOR				
HUMAN MEDICINE CREDIT					
	COURSE INFORMATION				
FALL SEMESTER 1997	08/25/97 - 12/12/97				
ANT 551	MEDICAL GROSS ANATOMY	6			P
BCH 521	MEDICAL BIOCHEMISTRY	5			P
HM 531	CLINICAL SKILLS I	2			P
HM 571	INTEGRATIVE CLIN CORREL I	2			P
HM 581	MENTOR PROGRAM	1			P
PSL 501	INTRO MEDICAL PHYSIOLOGY	3			P
CUM CREDITS : 19.0	CUM GPA : N/A				
SPRING SEMESTER 1998	01/14/98 - 05/08/98				
ANT 552	MEDICAL NEUROSCIENCE	4			P
ANT 562	MEDICAL HISTOLOGY	3			P
FMP 580	SPEC TOPICS IN FAMILY PRACTICE	2			P
HM 532	CLINICAL SKILLS II	2			P
HM 572	INTEGRATIVE CLIN CORREL II	2			P
HM 581	MENTOR PROGRAM	1			P
MIC 522	MEDICAL MICROBIO & IMMUNOLOGY	5			P
PTH 542	BASIC PRINCIPLES OF PATHOLOGY	2			P
RAD 553	INTRODUCTION TO RADIOLOGY	1			P
CUM CREDITS : 41.0	CUM GPA : N/A				
SUMMER SEMESTER 1998	05/18/98 - 08/19/98				
HM 533	CLINICAL SKILLS III	1			P
HM 543	HUMAN DEV & BEHAVIOR SOCIETY	5			P
HM 573	INTEGRATIVE CLIN CORREL III	1			P
HM 581	MENTOR PROGRAM	1			P
PHD 523	GENETICS FOR MEDICAL PRACTICE	1			P
PHM 563	MEDICAL PHARMACOLOGY	3			P
CUM CREDITS : 53.0	CUM GPA : N/A				

----------CONTINUED ON PAGE 02----------

PROVIDED SOLELY FOR: (1)
FEDERATION CREDS VERIFICATION BRD
FEDERATION OF STATE MED BOARDS
PO BOX 619850
DALLAS TX 75261

SEAL VERIFIED

Linda O. Stanford
Linda O. Stanford
University Registrar

22553 VLH (02301D)

THE FACE OF THIS TRANSCRIPT IS PRINTED WITH BLACK INK ON PAPER WITH GREEN BACKGROUND.

MICHIGAN STATE UNIVERSITY

OFFICIAL ACADEMIC TRANSCRIPT

WOOD, SHARON ANN

STUDENT ID: A21037521

HUMAN MEDICINE CREDIT

COURSE	TITLE	CRS	GRADE	S R	H
FALL SEMESTER 1998 08/31/98 - 12/18/98					
HM 511	INFECTIOUS DISEASE & IMMUNOLGY	3	P		
HM 512	DISORDERS BEHAVIOR & DEVELOP	3	P		
HM 515	CARDIOVASCULAR DOMAIN	4	P		
HM 525	PULMONARY DOMAIN	3	P		
HM 534	CLINICAL SKILLS IV	2	P		
HM 539	HEMATOPOIETIC/NEOPLASIA	3	P		
HM 546	SOC CONTEXT CLIN DECIS II	2	P		
HM 591	SPEC PROB IN HUMAN MEDICINE	1	P		
CUM CREDITS : 74.0	CUM GPA : N/A				
SPRING SEMESTER 1999 01/11/99 - 05/07/99					
FMP 580	SPEC TOPICS IN FAMILY PRACTICE	2	P		
HM 513	NEUROLOG & MUSCULOSKEL DOMAIN	4	P		
HM 514	MAJOR MENTAL DISORDERS	2	P		
HM 526	URINARY TRACT DOMAIN	4	P		
HM 527	DIGESTIVE DOMAIN	3	P		
HM 528	MET & ENDO & REPROD DOMAIN	3	P		
HM 535	CLINICAL SKILLS V	2	P		
HM 547	SOC CON CLIN DECISIONS II	2	P		
HM 548	MEDICAL HUMANITIES SEMINAR	2	P		
HM 591	SPEC PROB IN HUMAN MEDICINE	1	P		
CUM CREDITS : 99.0	CUM GPA : N/A				
SUMMER SEMESTER 1999 05/17/99 - 08/19/99					
FMP 602	CLIN MEDICINE IN THE COMMUNITY	6	P		
CUM CREDITS : 105.0	CUM GPA : N/A				
FALL SEMESTER 1999 08/30/99 - 12/17/99					
FMP 608	FAMILY PRACTICE CLERKSHIP	12	P		
HM 635	CORE COMPETENCIES I	2	P		
PHD 600	PEDIATRIC SPECIALTY CLERKSHIP	12	P		
CUM CREDITS : 131.0	CUM GPA : N/A				
SPRING SEMESTER 2000 01/10/00 - 05/05/00					
HM 636	CORE COMPETENCIES II	2	P		
MED 608	INTERNAL MEDICINE CLERKSHIP	12	P		
SUR 608	BASIC SURGERY CLERKSHIP	12	P		
CUM CREDITS : 157.0	CUM GPA : N/A				
SUMMER SEMESTER 2000 05/15/00 - 08/18/00					
HM 637	CORE COMPETENCIES III	2	P		
OGR 608	OBSTETRICS & GYNECOLOGY CLKSHP	12	P		
PSC 608	PSYCHIATRY & BEHAV SCIEN CKSHP	12	P		
CUM CREDITS : 183.0	CUM GPA : N/A				
FALL SEMESTER 2000 08/28/00 - 12/15/00					
MED 613	DERMATOLOGY CLERKSHIP	6	P		
MED 618	INFECTIOUS DISEASES CLERKSHIP	6	P		
MED 623	ADVANCED MEDICINE	6	P		
SUR 618	ANESTHESIA CLERKSHIP	6	P		
CUM CREDITS : 207.0	CUM GPA : N/A				
SPRING SEMESTER 2001 01/08/01 - 05/04/01					
FMP 617	SPORTS MEDICINE CLERKSHIP	6	P		
OGR 609	ADV OBSTET & GYNECOLOGY CLKSHP	6	P		
SUR 620	ADVANCED SURGERY CLERKSHIP	6	P		
CUM CREDITS : 225.0	CUM GPA : N/A				

DOCTOR OF MEDICINE GRANTED: 05/04/01
MAJOR: HUMAN MEDICINE
COLLEGE: HUMAN MEDICINE
----------NO ENTRIES BELOW THIS LINE----------

PROVIDED SOLELY FOR: (1)
FEDERATION CREDS VERIFICATION BRD
FEDERATION OF STATE MED BOARDS
PO BOX 619850
DALLAS TX 75261

SEAL VERIFIED

Linda O. Stanford
University Registrar

THE FACE OF THIS TRANSCRIPT IS PRINTED WITH BLACK INK ON PAPER WITH GREEN BACKGROUND.

MICHIGAN STATE UNIVERSITY
KEY TO TRANSCRIPT

Office of the Registrar
East Lansing, MI 48824-0210
Telephone (517) 353-4MSU
1-800-496-4MSU

The Family Educational Rights and Privacy Act of 1974 prohibits the release of this record or disclosure of its contents to any third party without the written consent of the student.

AUTHENTICATION OF THE TRANSCRIPT

There are two formats for transcripts. One is for students' records that are in the automated system; the other is for students' records not in the automated system. Both formats are printed with black ink on paper with green background which repeats MICHIGAN STATE UNIVERSITY over the entire page.

A transcript from the automated records system is official when it bears the signature of the Registrar and the University seal in black ink.

A transcript from the non-automated system is official when it bears the signature of the Registrar and the embossed University seal.

COURSE NUMBERING SYSTEM

001-099	Non-Credit and Institute of Agricultural Technology Courses
100-299	Undergraduate Courses
300-499	Advanced Undergraduate Courses
500-599	Graduate Courses prior to 1960
500-699	Graduate-Professional Courses
800-899	Graduate Courses
900-999	Advanced Graduate Courses

CREDITS

Effective Fall 1992 courses at Michigan State University are given on a semester basis. One credit normally requires three hours of effort a week in class, laboratory, and preparation. To convert to quarter credits, the semester credits should be multiplied by three halves (3/2).

Prior to Fall 1992 courses at Michigan State University were given on a quarter basis.

COURSES REPEATED

A course repeated is indicated differently depending on the transcript format. A transcript created from the automated system has a course repeated indicated by an S (Superseded) in the column headed SR. The course that repeated a superseded course is indicated by an R (Repeat) in the SR column.

In the non-automated system, the course that repeated the previous course is indicated by an R to the left of the course number.

For both formats, term credit and grade-point average (GPA) totals are not adjusted for repeats in the term of the superseded course. The summary totals for the level of the student are adjusted to include only the last entry.

HONORS

An "H" in the Honors column indicates an honors course, honors section of a course, or the student took a non-honors course as honors. The latter indicates additional work was completed beyond normal requirements.

GRADE-POINT AVERAGES

Grade points for each course are determined by multiplying the numerical grade by the number of credits for the course. Credits and grade points for courses in which P,I,N,DF,W,ET,CP,CR,NC,U or V have been received do not affect the grade-point average.

A grade-point average of 2.00 is required for graduation from the University for a bachelor's degree; 3.00 for graduate degrees.

The M.S.U. cumulative grade-point average appears on the automated transcript after each term.

To compute the M.S.U. cumulative grade-point average on the non-automated transcript, divide the total points earned at M.S.U. for all terms by the total credits carried at M.S.U. for all terms. Credit and point totals appearing on non-automated transcripts at the end of each term indicate:

Fall 1956 to present—total credits earned, total credits carried at M.S.U., total credits earned at M.S.U, and total points earned at M.S.U. to date.

Fall 1950 through Summer 1956—total credits carried, credits earned, and points earned to date.

Prior to Fall 1950—total credits and points earned to date.

CURRENT GRADING SYSTEM

THE NUMERICAL SYSTEM:

4.0, 3.5, 3.0, 2.5, 2.0, 1.5, 1.0, 0.0 - Credit is awarded for the following minimum levels—1.0 for undergraduate students and 2.0 for graduate students.

THE CREDIT-NO CREDIT SYSTEM:

CR-CREDIT-Undergraduates must perform at or above the 2.0 level. Graduates must perform at or above the 3.0 level.

NC-NO CREDIT - Performance was below 2.0 level for undergraduates and below 3.0 level for graduates.

THE PASS-NO GRADE SYSTEM:

P-PASS - Credit was granted and the student achieved a level of performance judged to be satisfactory by the instructor.

N-NO GRADE - No credit was granted and the student did not achieve a level of performance judged satisfactory by the instructor.

OTHER SYMBOLS USED:

W-WITHDREW	DF-DEFERRED
V-VISITOR	ET-EXTENSION
U-UNFINISHED	NGR-NO GRADE REPORTED
I-INCOMPLETE	CP-CONDITIONAL PASS

A transcript may temporarily reflect "LDR" as a grade for a course which was dropped late and to which a final grade has not yet been assigned.

PAST GRADING SYSTEMS

Prior to Fall 1988: N-NO GRADE indicated the student officially dropped the course after the middle of the term and was doing passing work, or there was no basis for a grade, or the student did not pass a course approved for grading on a P-N basis.

Fall 1968 to Winter 1972: The grades of 4.5 and 0.5 were included in the numerical system of grading. The 4.5 was awarded only for exceptionally high performance.

Prior to Fall 1969: X-Condition - Until removed and a grade reported, the course was considered to be a deficiency and was included in grade-point averages as a grade of 0.0 under the numerical system. The X-Condition had no affect on the grade-point average if enrollment was on the CR-NC system.

Prior to Fall 1968: A-excellent, B-good, C-fair, D-poor, F-failure, P-pass-given only in credit courses which were approved for grading on pass-fail basis.

PAST GRADE-POINT SYSTEMS

Fall 1968 to Winter 1972: Grades of 4.5 were included in computing grade-point averages only up to a point where the term or cumulative grade-point averages reached 4.00. Thus, the term grade-point average and the cumulative grade-point average was limited to 4.00.

Fall 1950 to Fall 1968: Four points for each credit graded A; 3 for B; 2 for C; 1 for D; 0 for F and X. No points were given for grades P,I,N,V, and DF.

Prior to Fall 1950: Three points for each credit graded A; 2 for B; 1 for C; 0 for D; and -1 for F and X.

O-22497 4-02 MSU Printing Services

Certified as a true copy of the diploma issued to Sharon A. Wood by the College of Human Medicine at Michigan State University on May 4, 2001.

Marsha D. Rappley, M.D.
Interim Associate Dean for Academic Affairs

November 18, 2002

Michigan State University

College of Human Medicine

Upon the Nomination of the Faculty and the Dean has conferred upon

Sharon A. Wood

the Degree of

Doctor of Medicine

Given under the Seal of the University at East Lansing in the State of Michigan on this fourth day of May in the year Two Thousand and One.

Chairperson, Board of Trustees

President of the University

SEAL
VERIFIED

Section IV

Postgraduate Training

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **University of Cincinnati Medical Center**
Attention: Program Director
Address: Department of Family Practice, Cincinnati, OH 45239
Affiliated University:

Verification For:
Name: **Wood, Sharon Ann**
SSN: [redacted]
DOB: **11/27/1974**
Individual's Name on Record (if different from above):

Program Participation:
Important: Report incomplete postgraduate years (PGY) separate from those that were successfully completed.
If the postgraduate year is currently in progress report the expected completion date in the "To" field.
Report Internships, Residencies and Fellowships separately.
Use one section per department. If the department is rotating or transitional, please provide a schedule of rotations.

PGY: 1
✓ Internship ___ Residency ___ Fellowship ___ Research
Department: Family Medicine
From: 7, 1, 2001 To: 6, 30, 2002
Successfully Completed?: ✓ Yes ___ No ___ In Progress
Accredited by: ✓ ACGME __AOA __LCGME __RSC __CFPC __RCPSC __APPAP __None of these

PGY: 2
___ Internship ✓ Residency ___ Fellowship ___ Research
Department: Family Medicine
From: 7, 1, 2002 To: 6, 30, 2003
Successfully Completed?: ___ Yes ___ No ✓ In Progress
Accredited by: ✓ ACGME __AOA __LCGME __RSC __CFPC __RCPSC __APPAP __None of these

PGY: ___
___ Internship ___ Residency ___ Fellowship ___ Research
Department: ___
From: ___/___/___ To: ___/___/___
Successfully Completed?: ___ Yes ___ No ___ In Progress
Accredited by: __ACGME __AOA __LCGME __RSC CFPC __RCPSC __APPAP __None of these

Unusual Circumstances:
Circle the correct response. Omitted responses require written explanation.
If necessary, you may continue your explanation on a separate sheet of paper.

Did this individual ever take a leave of absence or break from his/her training?	Yes **No**
Was this individual ever placed on probation?	Yes **No**
Was this individual ever disciplined or placed under investigation?	Yes **No**
Were any negative reports ever filed by instructors?	Yes **No**
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes **No**

Please explain any "Yes" response from above:
Signed before me by Dr Philip M Diller
Sharon F Mullen
SHARON F. MULLEN
Notary Public, State of Ohio
My Commission Expires April 6, 2005

Certification:
Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Philip M. Diller, M.D., Ph.D., Director
Family Medicine Residency Program
2446 Kipling Avenue Ph: 513 853 4350
Cincinnati, OH 45239

Signature: PMDiller
Date of Signature: 2/18/03
Tel: ___ Fax: 513 541 5902 E-Mail: ___

Section V

Examination History/Score Transcripts

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

USMLE United States Medical Licensing Examination™

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 11/11/2002

Federation Credentials Verification Service
ATTN: Ohio
Packet ID: 27553

Examinee: Wood, Sharon Ann
USMLE ID#: 5-058-328-5
DOB: 11/27/1974
Alt Name(s):

Results for all 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. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	6/9/1999	PASS	218	(179)	87	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	8/22/2000	PASS	216	(174)	86	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
OHIO	8/19/2002	PASS	210	(182)	85	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Patent 5636874

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

March 24, 2003

Sharon Wood, MD
3326 Renfro Ave.
Cincinnati, OH 45211

Dr. Wood:

Enclosed is a revised licensure letter. Please be advised that the original license number reported to you is incorrect. Your license number is **82315** not 83215 as originally reported.

I apologize for the inconvience.

Sincerely,

Penny E. Grubb
Chief, Licensure

13754-3542

OC
10/30/02 KKR

MEDICINE OR OSTEOPATHIC MEDICINE
PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

OCT 11 2002

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	Wood	Sharon	Ann	

High School or Equivalent

School Name: Chippewa Hills High School

City: Remus | State: MI | Country: USA 49340-50

Dates Attended: From: MO/YR 6 '89 To: MO/YR 6 '93

Undergraduate College or Equivalent

School Name: Michigan State University

City: E. Lansing | State: MI | Country: USA

Dates Attended: From: MO/YR 8 '93 To: MO/YR 5 '97 | Degree Received: BS

School Name:

City: | State: | Country:

Dates Attended: From: MO/YR / To: MO/YR / | Degree Received:

Medical or Osteopathic School of Graduation

School Name: Michigan State University

City: E. Lansing | State: MI | Country: USA

Dates Attended: From: MO/YR 8 '97 To: MO/YR 5'01 | Degree Received: MD

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 102521 DATE ISSUED: 11-1-02

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

Kay Kreve
Entrance Examiner

Anand G. Garg
Secretary

AFFIDAVIT AND RELEASE OF APPLICANT
MEDICINE OR OSTEOPATHIC MEDICINE

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 incomplete.

ss STATE OF: Ohio

COUNTY OF: Hamilton

OCT 11 2002

I, Sharon Ann Wood, 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 neither 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 a license to practice 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 occurs at any time prior to a license to practice medicine or osteopathic medicine 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 a license to practice medicine or osteopathic medicine and that any fee I submitted is neither 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 based 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.

Sharon A. Wood
Signature of Applicant

Subscribed and sworn to before me this 1st day of October 2002.

Sharon F. Mullen
Signature of Notary Public

(NOTARY SEAL)

SHARON F. MULLEN
Notary Public, State of Ohio
My Commission Expires April 6, 2005
Date Commission Expires

Date Posted: 6/23/2005 9:35:57 AM

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

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

Address Information

BUSINESS ADDRESS	Planned Parenthood SW Ohio 2314 Auburn Ave. CINCINNATI, OH 45219 Hamilton County United States of America 513-287-7635
CREDENTIAL MAIL ADDRESS	3326 Renfro Ave. CINCINNATI, OH 45211 Hamilton County United States of America 513-481-1545

License Information

License Number	35.082315
License Name	SHARON LINER
Email Address	

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY PRACTICE

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

. . . . . GYNECOLOGY

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . 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.**

. . . . . Sarah Wilson, WHNP; Sarah Ferguson, CNMW; Jennifer Jones, WHNP; Gail Draut FPNP; Tammy Schwing WHNP; Bev Wells NP; Crystal Wilmhoff WHNP

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: 9/13/2007 4:33:58 PM

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

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

License Information

License Number	35.082315
License Name	SHARON LINER
Email Address	sharonliner@hotmail.com

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

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

. . . . . GYNECOLOGY

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.**

. . . . . Crystal Wilmhoff, WHNP; Sarah Kramer, WHNP; Tamara Schwing, Family NP; Anne Etges, WHNP

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

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

Date Posted: 6/18/2009 9:41:07 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	Planned Parenthood SW Ohio 2314 Auburn Ave. CINCINNATI, OH 45219 Hamilton County United States of America 513-721-7635 sliner@ppswo.org
CREDENTIAL MAIL ADDRESS	6 Hollow Oak Cincinnati, OH 45241 Hamilton County United States of America 513-481-1545 sharonliner@hotmail.com

License Information

License Number	35.082315
License Name	SHARON LINER

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

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

. . . . . GYNECOLOGY

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.**

. . . . . Beka Abraham, CNP; Molly Dickinson, CNM; Tracy Dillingham, CNM; Sarah Kramer, CNP; Barbara Persons, CNP; Leslie Stidd, CNP; Julie Treadway, CNP; Cynthia Trent, CNP; Whitney Vangen, CNP; Beverly Wells, CNP; Crystal Wilmhoff, CNP; Sarah Wilson, 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: 8/22/2011 3:14:49 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

6 Hollow Oak
Cincinnati, OH 45241
Hamilton County
United States of America
513-481-1545
sliner@ppswo.org

License Information

License Number 35.082315
License Name SHARON LINER

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

. . . . . FAMILY MEDICINE

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

. . . . . GYNECOLOGY

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 maintainrecords 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.**

. . . . . Jennifer Battaglia, CNP; Laura Boyle, CNP, CNM; Julie Cuy Castellanos, CNP; Melinda Chimento, CNP; Jessica Crider, CNP; Tracy Dillingham, CNM; Robin Gulley, CNP, Allison Heist, CNP; Beverly Wells, CNP; Crystal Wilmhoff, CNP; Sarah Wilson, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 30-34

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

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 1-4

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

. 1-4

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

. 0

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

. 0

Clinical - Practice setting

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

. 35-39

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

. 0

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 45219

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45245

4. Enter the second county:

. . . . . Clermont

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Spanish

2. Select a language from the drop down list.

. . . . . *{not Answered}*

3. Select a language from the drop down list.

. . . . . *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

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: 4/18/2013 2:43:25 PM

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

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

License Information

License Number	35.082315
License Name	SHARON LINER

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

. . . . . FAMILY MEDICINE

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

. . . . . GYNECOLOGY

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.**

. . . . . Aurora Cardenas-Ball, CNP – Women's Health, Julie Cuy-Castellanos, CNP – Women's Health, Melinda Chimento, CNP – Women's Health, Jessica Crider, CNP – Women's Health,Tracy Dillingham, CNP – Family Health and CNMW – Nurse Midwife, Robin Gulley, CNP – Women's Health, Allison Heist, CNP – Women's Health, Jessica Moon, CNMW – Nurse Midwife, Gwynne Rohrs, CNMW – Nurse Midwife, Michelle Schlarmann, CNP – Women's Health, Misty Uhl, CNP – Women's Health, Beverly Wells, CNP – Adult Health, Crystal Wilmhoff, CNP – Women's Health, Sarah Wilson, CNP – Women's Health

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 25-29

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

setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 10-14

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

. 0

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

. 0

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

. 0

Clinical - Practice setting

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

. 30-34

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

. 0

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 45219

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45245

4. Enter the second county:

. . . . . Clermont

5. Enter the third zip code:

. 45402

6. Enter the third county:

. . . . . Butler

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.

. . . . . 2314 Auburn Ave, Cincinnati, OH 45219; 290 Northland Blvd, Cincinnati, OH 45246;2016 Ferguson Road,Cincinnati, OH 45238; 834 Ohio Pike/State Rt. 125, Withamsville, OH 45245; 11 Ludlow Street, Hamilton, OH 45011; 224 N Wilkinson Street, Dayton, OH 45402; 1061 North Bechtle Avenue, Springfield, OH 45504

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Spanish

2. Select a language from the drop down list.

. . . . . *{not Answered}*

3. Select a language from the drop down list.

. . . . . *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

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

. 1568497220

DEA number

1. Please enter your DEA number

. . . . . BL8266098

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: 4/30/2015 3:00:47 PM

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

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

License Information

License Number	35.082315
License Name	SHARON LINER

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

. . . . . FAMILY MEDICINE

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

. . . . . GYNECOLOGY

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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, 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.**

. . . . . Julie Cuy Castellanos, CNP; Melinda Chimento, CNP; Jessica Crider, CNP; Tracy Dillingham, CNP; Michelle Huffman, CNP; Gwynne Rohrs, CNM; Audra Trillana, CNP; Misty Uhl, CNP; Crystal Wilmhoff, CNP; Amanda Winning, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 30-34

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

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 5-9

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

. 5-9

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

. 0

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

. 0

Clinical - Practice setting

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

. 30-34

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

. 0

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 45219

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 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)

. . . . . YES

Workforce Language Question

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

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Spanish

2. Select a language from the drop down list.

. . . . . *{not Answered}*

3. Select a language from the drop down list.

. . . . . *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

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

. 1568497220

DEA number

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

. . . . . BL8266098

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . YES

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . NO

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

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