MyLicense Renewal Question Responses

License Number: MD419734

Name : ANN IRENE SCHUTT-AINE

Online Submission Date :

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Is your malpractice insurance coverage current?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state territory or country?	N
Since May 19, 2002, have any malpractice complaints been filed against you?	N

Online Submission Date : 11/11/2004 9:08:03AM

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you provide health care services to patients within the Commonwealth of PA?	Y
If yes, is the percentage of patients that you provide care for in the Commonwealth 20% or more of your practice?	Y
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

Online Submission Date : 10/10/2006 8:27:55AM

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N

Physician Renewal Question Responses

License Number: MD419734

Name : ANN IRENE SCHUTT-AINE

Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

32919

PA STATE BOARD OF MEDICINE
PO BOX 2649
HARRISBURG PA 17105

ANN IRENE SCHUTT-AINE [redacted]

TO REGISTER YOU WILL NEED:
Last Name: SCHUTT-AINE
License Number: MD419734
Registration Code: 25013419

INFORMATION REGARDING RENEWAL OF YOUR LICENSE

Expiration Date: 12/31/08

The Pennsylvania State Board of Medicine offers you the ability to renew your license online. You will need: 1) a valid credit card (Visa, Mastercard, Discover, American Express) and 2) your Registration Code **25013419.** Go to www.myLicense.state.pa.us to renew online. Follow the instructions and you will have immediate confirmation that your renewal is being processed. If you need assistance during the online renewal process, please email st-my-license-helpdesk@state.pa.us.

DO NOT RETURN THIS FORM IF YOU RENEW ONLINE.
This is NOT a renewal application.
To request a paper renewal application, follow the directions below.

If you are unable to use the online renewal system, you will need a paper renewal application to complete your renewal. PLEASE NOTE that you will not receive a paper renewal application as in years past. This is the only license renewal notice you will receive, unless you request a paper renewal application. **Board staff will not be able to take requests for paper renewal applications over the telephone due to the high volume of calls.** Therefore, the following options are available to receive a paper renewal application:

- BY MAIL Complete the information below and return this form to:

  PA State Board of Medicine
  P.O. Box 2649
  Harrisburg, PA 17105-2649

- BY WEBSITE www.dos.state.pa.us/med

We encourage you to renew by December 1, 2008 to ensure that you receive your license by the expiration date.

☐ Yes, I need a paper renewal application.

☒ I have a change of address. NEW ADDRESS: [redacted]

Social Security Number _____

☒ **I will not be practicing this profession in Pennsylvania after December 31, 2008. Please place my license on inactive status. (Return this form to the address above. No fee or continuing education is required.**

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
717-783-1400
717-787-2381

Courier Delivery Address
State Board of Medicine
124 Pine Street, 1st Floor
Harrisburg, PA 17101

OFFICIAL USE ONLY

MT-047906-T

SCHOOL APPL

APPLICATION FOR A GRADUATE LICENSE FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS

THIS APPLICATION IS TO BE USED FOR INITIAL GRADUATE LICENSE - DO NOT USE TO RENEW

FEE - $15.00
MAKE FEE PAYABLE TO COMMONWEALTH OF PENNSYLVANIA
FEE NOT REFUNDABLE
NOTE: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

Official Use Only
Amount 15.00
Date 5/16/00
3148100

THIS APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS PRIOR TO START OF TRAINING

TO BE COMPLETED BY APPLICANT:

Please Print or Type

NAME: [redacted] (LAST, FIRST, MIDDLE, MAIDEN)

ADDRESS: [redacted]

(CITY, STATE, ZIP CODE)

SOCIAL SECURITY [redacted] DATE OF BIRTH: [redacted] TELEPHONE NUMBERS: [redacted] (WORK) (HOME)

NAME & ADDRESS OF MEDICAL SCHOOL	DATES OF ATTENDANCE	DATE OF GRADUATION
Boston Medical Center Boston, MA	9/1996 - 6/2000	6/6/2000

NAME & ADDRESS OF HOSPITAL(S)	DATES OF PREVIOUS TRAINING	SPECIALTY

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL: University Health Center of Pittsburgh HS- 000288

ADDRESS OF HOSPITAL: 121 Meyran Ave., 201 Loeffler Bldg., Pittsburgh, PA 15260

YEAR IN TRAINING: 1 SPECIALTY: OB-GYN LEVEL IN TRAINING (PGY): 1

DATES OF TRAINING REQUESTED: 7-21-00 (BEGINNING DATE-MONTH-DAY-YEAR) TO 6-30-01 (ENDING DATE-MONTH-DAY-YEAR)

NAME OF PROGRAM DIRECTOR: William R. Crombleholme, MD

SIGNATURE OF PROGRAM DIRECTOR: William R. Crombleholme MD
Clinical Professor

Answer the following questions. If "YES" is answered to any of them, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	YES	NO
1. Do you hold a license to practice medicine and surgery (active or inactive, current or expired) in any state, territory or country? If "yes", list all states below.	____	✓
2. Have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in another state, territory or country?	____	✓
3. Has any disciplinary action been taken against your license in another state, territory or country?	____	✓
4. Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?	____	✓
5. Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?	____	✓
6. Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	____	✓
7. Are you, or have you ever been addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? (NOTE: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Health Monitoring Program.)	[redacted]	

****

SIGNED STATEMENT

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant: [signature]

Date: 3/23/06

ANN I. SCHUTT-AINE

[redacted]

Education

1996-Present — Harvard Medical School
Boston, MA
MD expected June 2000

1992-1996 — Yale University
New Haven, CT
BS in Biology with distinction, cum laude

Honors & Awards

1997-Present — *Scholar*
National Health Service Corps Scholarship Program
• Received a full academic medical school scholarship

1999-2000 — *Fellow*
W.K. Kellogg Community Medicine Training Fellowship
Mattapan Community Health Center, Boston, MA
• Attained experience in the philosophy and practices of community medical centers
• Evaluated and improved upon the Pap smear tracking system to refine patient care

Research Experience

August 1995 - May 1996 — *Independent Research*
Ivyin Jones, MD, PhD, advisor, Yale University
Senior Thesis, Biology: Effect of TSH on *In Vitro* Mouse Folliculogenesis
• Developed an *in vitro* model to study murine ovarian folliculogenesis

Summer 1994 — *Student Research Assistant*
Misha Protic, PhD, National Institutes of Health, Bethesda, MD
• Performed DNA cloning and sequencing experiments
• Assisted with general lab maintenance

Extracurricular

1999-Present — *American College of Obstetrics and Gynecology*, Medical Student Section

1996-Present — *Student National Medical Association*
• Participated in health promotion projects
• Served as Vice President of Harvard Chapter, 1997-98

1997-Present — *Pre-Medical Advisor*
Pforzheimer House, Harvard College
• Responsible for writing composite letters of recommendation for medical school

September 1996 - June 1998 — *Volunteer*
Manville School Mentoring Program, Boston, MA
• Acted as "Big Sister" for 12-year old girl with behavioral and social difficulties

September 1997 - March 1998 — *Volunteer*
Mo Vaughn Youth Development Program, Dorchester, MA
• Served as a mentor/teacher at his after-school tutoring and youth development program

Summer 1997 — *Member*
Urban Health Project, Harvard Medical School
• Student-run organization which combines individual community service projects with ongoing group community service and health education initiatives

Personal

Proficient in Spanish
Hobbies include jogging, swimming, and reading

State Board of Medicine
717-783-1400
717-787-2381

3/16/00

OFFICIAL USE ONLY

VERIFICATION OF MEDICAL EDUCATION
For Graduates of Accredited Medical Schools.

E D U C

SECTION 1: To be completed by applicant:

Name: Schultz Anne Anna T.
Last First Middle

Name of medical school: Harvard Medical School

Location: Boston, MA

SUBMIT THIS VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL SCHOOL ENVELOPE.

SECTION 2: To be completed by Dean or Registrar of medical school:

Name of medical student: [illegible]

Date student began to attend this medical school: [illegible]
Month Day Year

Date of graduation: [illegible]
Month Day Year

[Seal of School]

I certify that all of the above information is correct.
Signature of
Dean or Registrar: [signature]

Date: [illegible]

Upon completion, school must return this completed from directly to the Pennsylvania State Board of Medicine in official school envelope. DO NOT RETURN TO APPLICANT.

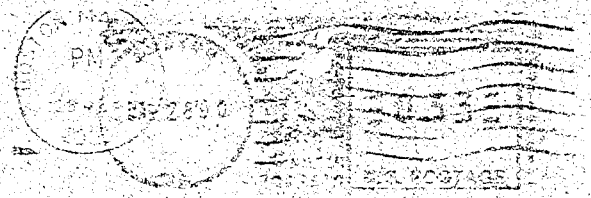
****

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649 U.S.A.

Courier Delivery Address
State Board of Medicine
124 Pine Street, 1st Floor
Harrisburg, PA 17101 U.S.A.

MAR 23 2000

HARVARD MEDICAL SCHOOL
OFFICE OF THE REGISTRAR
25 SHATTUCK STREET
BOSTON, MASSACHUSETTS 02115-6092



RECEIVED
MAY 0 8 2000
Health Licensing Boards

State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

020191 0309

49-5(1) (REV 12-01)

MD 419734

SCHUTAPPL

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
medicine@pados.state.pa.us
Courier Delivery Address
STATE BOARD OF MEDICINE
124 PINE STREET, 1st FLOOR
HARRISBURG, PA 17101

5951

Amount 35.00

Date 2/28/02

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION
For Graduates of **ACCREDITED** Medical Schools

Application Fee: $35.00 *not refundable*
Make check payable to the "Commonwealth of Pennsylvania."

12-0 M

Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment

Please print or type

NAME: Schutt Anne Ann Irene
Last First Middle

Permanent Address: [redacted]
City State Zip Code

Email address: [redacted]

Date of Birth: [redacted] Social Security Number: [redacted]

If your medical/licensure records are listed under another name or names list below:

LIST MEDICAL SCHOOL(S) ATTENDED:
Harvard Medical School

DATES OF ATTENDANCE
From: 9/1996 to 6/2000
Mo. & Yr. Mo. & Yr.
From: _____ to _____
Mo. & Yr. Mo. & Yr.

Date of Graduation: June 8, 2000

49-391 (REV 12-99)

Check licensing examination(s) passed:

( ) FLEX - indicate state where taken: _____ Date taken: _____
( ) FLEX COMPONENT 1 - indicate state where taken: _____ Date taken: _____
( ) FLEX COMPONENT 2 - indicate state where taken: _____ Date taken: _____
( ) NATIONAL BOARD - PART I _____ PART II _____ PART III _____
(✓) USMLE - STEP 1 ✓ STEP 2 ✓ STEP 3 ✓
( ) LMCC - Canadian
( ) STATE BOARD - indicate state where taken: _____

Post Graduate Education:

PGY Hospital: Magee-Womens Hospital From: 6/21/00 to: 6/20/01

PGY2 Hospital: Magee - Womens Hospital From: 6/21/01 to: 6/19/02

****

Answer the following questions, if "YES" is answered to any of them, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	YES	NO
1) Do you hold licensure or certification (active or inactive, current or expired) to practice in any other jurisdiction? If yes, list each one.		✓
2) Have you ever withdrawn an application for a license, had an application denied or refused, or agreed not to reapply for a license in another state, territory or country? A license includes a registration or certification.		✓
3) Has any disciplinary action been taken against your license or certificate in another state, territory or country?		✓
4) Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict at to any felony or misdemeanor, including any drug law violation, in any state or federal court?		✓
5) Have you had practice privileges denied, revoked or restricted at a hospital or other health care facility?		✓
6) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
7) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs. Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)	[redacted]	

SIGNED STATEMENT

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

[redacted] 5/3/02

SIGNATURE OF APPLICANT DATE

020194 0309

State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Certification of Moral Character

To be completed by two physicians with a license without restriction in good standing in the United States or Canada.

Name of Applicant: Ann Schultz-Ainé

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 1 year(s) 11 month(s).

SIGNATURE: Daniel Landers M.D. Date: 5/9/02

Print or type name as signed above: DANIEL V. LANDERS, M.D.

State in which licensed: Pennsylvania License Number: MD 055343-L

Name of Applicant: Ann Schultz-Ainé

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 1 year(s) 11 month(s).

SIGNATURE: [illegible] Date:

Print or type name as signed above: [illegible]

State in which licensed: [illegible] License Number: [illegible]

Return Completed Form to Applicant

020104-8309

49-161(R)(V 12-01)

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
State Board of Medicine
124 Pine Street, 1st floor
Harrisburg, PA 17101

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING

Accredited Medical School Graduates

TO BE COMPLETED BY APPLICANT

NAME: Schutt-Aine Ann J.
Last First Middle

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year may be ACGME approved and can be any specialty. See listing on back.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

To be completed by the program director at the hospital where the graduate training occurred. If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

NAME OF HOSPITAL WHERE TRAINING WAS COMPLETED: Magee-Womens Hospital

NAME OF SPONSORING INSTITUTION: University Health Center of Pittsburgh

LOCATED IN: Pittsburgh PA
City State

1st Year from 7/1/99 To 6/30/00 Specialty OB/GYN Level(PGY) 1

2nd Year from 7/1/00 To 6/30/01 Specialty OB/GYN Level(PGY) 2

→ "I certify that Ann Schutt-Aine successfully completed will successfully complete this
(Name of Applicant)
graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."

"I further certify that the above program was ACGME accredited at the time Ann Schutt-Aine ***completed the training."***
(Name of Applicant)

Signature of Program Director: M. William Croom Blasing MD

[Seal of Hospital]

Date: 6/19/02

If the hospital has no seal complete the following section and have this form notarized:

I Hereby certify that my hospital has no seal or stamp and that this form was completed by this hospital.

Program Director's Signature: _____

Date: _____ [notary seal]

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE.

A

020194 0309

DIANA BRUCHA
4126411092
UPMC
300 HALKET ST
PITTSBURGH PA 15213

LTR 1 OF 1

SHIP TO:
STATE BOARD OF MEDICINE
124 PINE STREET, 1ST FLOOR
HARRISBURG PA 17101

PA 171 9-20

UPS NEXT DAY AIR

TRACKING #: 1Z AX4 042 01 9375 9478

1

BILLING: P/P

Reference No.1: 34774
Reference No.2: MD - PROG DIRE

TM

XOL 01.11 WOOLE501 URC18 04/2002

MCBB85 TRAINEE SPECIALTY HISTORY - INQUIRY 6/02/98 0309 11:53

License Number MT 047906 T Name SCHUTT-AINE,ANN IRENE

Beginning Date	Ending Date	Level	Specialty	Related Lic
6-21-2001	6-20-2002	2	OBG OBSTETRICS AND GYNECOLOGY	HS 000288 L
6-21-2000	6-20-2001	1	OBG OBSTETRICS AND GYNECOLOGY	HS 000288 L

PRESS HELP=HELP F3=EXIT PAGE DOWN=NEXT RECORDS PAGE UP=PRIOR RECORDS

PHS13 APPLICANT - INQUIRY 6/13/02 15:11:39

020194 0309

Applicant Number: MT 047906 T
Name: SCHUTT-AINE,ANN IRENE
Address: NO STREET ADDRESS

City: NO CITY State: Zip: 00000 0000
SSN/Tax ID: 219086267 Level: I Specialty: OBG

Business Name Code: N
Entry Date: 05 / 16 / 2000
Completion Date: 05 / 20 / 2000
Beginning Date: 06 / 21 / 2000
Ending Date: 06 / 20 / 2001
Birth Date: [redacted]

Related License Number: HS 000288 L UNIVERSITY HEALTH CENTER

Date Reported	Description	A/R/N	Comments
00 / 00 / 0000	ECFMG		
00 / 00 / 0000	EXAM SCORES		
00 / 00 / 0000	UNREST LICENSE		
05 / 20 / 2000	MEDICAL EDUCATION	A	HARVARD 96/00 DIRECT
00 / 00 / 0000	OFFICIAL DOCUMENT/TRANS		

F1-Exit F10-Next

020194 0309

Updated Curriculum Vitae Information

Ann L. Schuff-Aine, M.D.

[redacted]

Post-Graduate Education

6/2000 to Present
University Health Center of Pittsburgh
Magee-Womens Hospital
300 Halket Street
Pittsburgh, PA 152130
Ob/Gyn Residency Training
William R. Crombleholme, M.D., Program Director

020194 0309

Anh Irene Schuh-Aipe

[redacted]

Medical Education

Harvard Medical School - Boston,MA
09/1996 - 06/2000
MD, 06/2000

Undergraduate Education

Yale University, New Haven, CT
08/1992 - 05/1996
BS, cum laude, Biology

Medical School Honors/Awards

Scholar, National Health Service Corps Scholarship Program
Fellow, W.K. Kellogg Community Medicine Training Fellowship

Employment

05/1993 - 08/1995
Conrad J. Duncan, MD
Medical Assistant
Assisted with office procedures as well as patient scheduling and billing.

Research Experience

08/1995 - 05/1996
Yale University, Department of Biology
Independent Research
Advisor: Irving Jones, MD, PhD Senior Thesis, Department of Biology: "Effect of TSH on In Vitro Mouse Folliculogenesis" Developed an in vitro model to study murine ovarian folliculogenesis.

05/1993 - 08/1993
National Institutes of Health
Student Research Assistant
Preceptor: Misha Protic, PhD Performed DNA cloning and sequencing experiments.

Volunteer Experience

09/1997 - 05/1998
Mt. Vaughn Youth Development Program
Mentor/Teacher
This program is an after school tutoring and youth development program for adolescents aged 11-18. I assisted with homework, assignments and organized workshops on various subjects, including goal setting and dealing with sexuality.

09/1997 - 05/1997
Uganda Health Project

Member
One of fourteen first year medical students selected to participate in this organization which combines an individual summer-long community service project with ongoing group community service and health awareness initiatives.

04/1997 - 06/2000
Pforzheimer House, Harvard College
Pre-Medical Advisor
Served as mentor/advisor to Harvard undergraduate students. Responsible for writing the composite letter of recommendation for medical school applicants.

09/1996 - 06/1998
Manville School Mentoring Program
Mentor/Big Sister
Acted as Big Sister to 12 year old girl with behavioral and social difficulties.

Licensure

USMLE Step 1 06/1998

Language Fluency (Other than English)

Spanish

Other Accomplishments

Student National Medical Association: Served as Vice-President of Harvard Chapter, 1997-98. Continue to participate in the group's health promotion and education projects American College of Obstetrics and Gynecology: Member of medical student section.

Hobbies/Interests

Reading, jogging, swimming

State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
717-783-1400 or 717-787-2381

June 14, 2002

ANN SCHUTT-AINE

[redacted]

Dear Doctor:

The items checked below are required to complete your application. Additional information is listed below the item, if necessary. **You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Medicine has issued a license.**

___ 1 Application - page 1

___ 2 Application - page 2

___ 3 Application page 3 - Certification of Moral Character

___ 4 Application - page 4 - Verification of ACGME Approved Graduate Medical Training - **must be received DIRECTLY from the Hospital(s) in official hospital envelope(s).**

___ 5 Application - page 6 - Verification of Medical Education - must be received DIRECTLY from the Medical School in an official Medical School envelope.

___ 6 National Board scores - Endorsement of Certification - **must be received DIRECTLY from the National Board in an official agency envelope**

___ 7 LMCC score certification **must be received DIRECTLY from the Medical Council of Canada in an official agency envelope**

___ 8 USMLE scores **must be received DIRECTLY from the Federation of State Medical Boards, Inc. in an official agency envelope.**

___ 9 FLEX scores **must be received DIRECTLY from the Federation of State Medical Boards, Inc. in an official agency envelope**

___ 10. State Board certification must be received DIRECTLY from the State Medical Board in an official State Board envelope

___ 11. Curriculum vitae

___ 12. Fee in the amount of $35.00 made payable to the "Commonwealth of Pennsylvania." Check or money order must be drawn on a US bank. **NOTE: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.**

***NEW FEE REGULATIONS WENT INTO EFFECT ON 2/12/02. THE BOARD HAS RETAINED YOUR $20 FEE. AN ADDITIONAL $15 WILL BE NEEDED.**

___ 13. Letter(s) of good standing must be received DIRECTLY from the State Board in an official State Board envelope from the following states:

___ 14. National Practitioner Data Bank / Healthcare Integrity and Protection Data Bank Disclosure Information – NPDB & HIPDB

___ 15. Other:

APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS WILL REQUIRE UPDATES OF CERTAIN SECTIONS.

Official Use Only 000247

M T - 0 4 7 9 0 6 - T

SSN 2-19-08-6267

S C H U T R N E W

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105-2649
717-783-1400

APR 26 2001

ANN IRENE SCHUTT-AINE
UNIVERSITY HEALTH CENTER
DEPT OF MED EDUCATION
121 MEYRAN AVENUE
201 LOEFFLER BUILDING
PITTSBURGH, PA 15260

RECEIVED DIRECT

Present Training Period:

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name
06/21/2000	06/20/2001	1	OBG	HS-000288-L	UNIVERSITY HEALTH CENTER

THIS IS YOUR RENEWAL NOTICE

1. Renewal Training Period:

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name
06/21/01	06/20/02	2	OBG	HS-000288L	UNIVERSITY HEALTH CTR

2. If you are not training in PA past ending date, check here. ___

3. Required Attachment - See #3A on instruction page.

Physician must answer all questions, sign and date form.

	Yes	No
4. Do you hold a license to practice medicine and surgery in any other jurisdiction? If yes, list each one:	___	✓
5. Since your last renewal, has any disciplinary action been taken against your license in another state, territory or country?	___	✓
6. Since your last renewal, have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court.	___	✓
7. Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?	___	✓
8. Since your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	___	✓

Signature

4/4/01
Date

[illegible]
MT04[illegible]
SCHUTT-AINE

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

RENEWAL APPLICATION

ANN IRENE SCHUTT-AINE
UNIVERSITY HEALTH CENTER
DEPT OF MED EDUCATION
121 MEYRAN AVENUE
201 LOEFFLER BUILDING
PITTSBURGH PA 15260

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

☐ I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required.** QUESTIONS MUST STILL BE ANSWERED.

THE FOLLOWING QUESTIONS MUST BE ANSWERED.

YES	NO	If YES to 2-8 - provide details AND attach certified copies of legal document(s).
	X	1. Do you hold a license to practice this profession in any other state or jurisdiction? List:
	X	2. Since your initial application or your last renewal, have you had disciplinary action taken against your license in any state or jurisdiction?
	X	3. Since your initial application or your last renewal, have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in any state or jurisdiction?
	X	4. Since your initial application or your last renewal, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
	X	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses, or drug offenses in any state, territory, or country?
	X	6. Since your initial application or your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	X	7. Since your initial application or your last renewal, have you had your [illegible] registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	X	8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the filing date and the date you were served.

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	06/21/2002	06/20/2005	[illegible]	[illegible]	[illegible]	UNIVERSITY HEALTH CENTER
Renewal	[illegible]	[illegible]	[illegible]			

Signature of Licensee (Mandatory): [signature] Date: [illegible]

SSN [redacted]

ATTACHMENTS FOR RENEWING:
- FEES – [illegible] check payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A [illegible] fee will be assessed for a returned payment.
- LATE FEE – [illegible]. Late renewal fee will be assessed if postmarked after the expiration date.
- PGY 2 LEVEL – [illegible] National Board Part 1 and 2 scores OR an acceptable combination as indicated in the regulations.
- PGY 3 LEVEL or above – Copy of your [illegible] National Board Parts 1-3 scores OR an acceptable combination as indicated in the regulations OR a copy of your [illegible] license WHICH SHOWS THE CURRENT EXPIRATION DATE.

Commonwealth of Pennsylvania
Department of State
Bureau of Professional and Occupational Affairs
PO Box 2649 Harrisburg PA 17105-2649

01-07-2006

License Type
Medical Physician and Surgeon

License Status
Active

Initial License Date
06/14/2002

ANN IRENE SCHUTT-AINE
[redacted]

License Number
MD419734

Expiration Date
12/31/2004

[redacted]
Acting Commissioner of Professional and Occupational Affairs

[redacted]
Signature

MT[illegible]
SCHUTT-AINE

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

RENEWAL APPLICATION

ANN IRENE SCHUTT-AINE
UNIVERSITY HEALTH CENTER
DEPT OF MED EDUCATION
SUITE 401 MEDICAL ARTS BUILDING
3708 FIFTH AVENUE
PITTSBURGH PA 15213

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649

MAY 2 [illegible] 2004

[x] I will not be participating in graduate training in Pennsylvania after the expiration date indicated below and request inactive status. No fee is required. QUESTIONS MUST STILL BE ANSWERED.

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to 2-8 – provide details AND attach certified copies of legal document(s)
	✓	1. Do you hold a license to practice this profession in any other state or jurisdiction? [illegible]
	✓	2. Since your initial application, or your last renewal, have you had disciplinary action taken against your license in any state or jurisdiction?
	✓	3. Since your initial application or your last renewal, have you withdrawn an application for a license, had an application for a license denied or refused or agreed not to reapply for a license in any state or jurisdiction?
	✓	4. Since your initial application or your last renewal, have you been convicted, found guilty, pleaded nolo contendere, or received probation without verdict or [illegible] to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
	✓	5. Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory, or country?
	✓	6. Since your initial application or your last renewal, have you had privileges denied, revoked or restricted in a hospital or other health care facility?
	✓	7. Since your initial application or your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency [illegible]?
	✓	8. Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the filing date and the date you were served.

Please review and update, as necessary, the following information regarding your license:

	Beginning Date	Ending Date	Level	Specialty	Hospital #	Hospital Name
Current	07/1/2003	6/30/2004	[illegible]	Obstetrics and Gynecology	[illegible]	UNIVERSITY HEALTH CENTER
Renewal						

Signature of Licensee (Mandatory): [signature] Date: 5/[illegible]/04

SSN [redacted]

ATTACHMENTS FOR RENEWING:
[illegible]
LATE FEE [illegible]
[illegible] LEVEL [illegible]
[illegible] LEVEL [illegible]

Department of State
Bureau of Professional and Occupational Affairs
STATE BOARD OF MEDICINE

Mailing Address:
P.O. Box [illegible]
Harrisburg, PA [illegible]

Courier Mail:
[illegible] North [illegible] Street
Harrisburg, PA 17110

Telephone: [illegible]
Fax: [illegible]
[illegible]
[illegible]

REQUEST FOR CHANGE OF NAME AND/OR ADDRESS

Complete the following information and check the appropriate block below:

Current Information:

Last Name: S C H U T T E [illegible] A [illegible] N B [illegible]

First Name: [illegible] N N [illegible] Middle Initial: [illegible]

License Number: M D [illegible] [illegible] R [illegible] [illegible] [illegible]

Social Security Number: [redacted]

☐ **Change of Name**

[illegible] a copy of a legal document verifying your name change. The following are [illegible] name changes [illegible]:

[illegible]
[illegible] resuming of your maiden name
[illegible] the resuming of a maiden name
[illegible] of the legal document must be provided.

New Name:

[illegible] Middle

☐ **Change of Address**

Old Address:

[illegible]

[illegible] Zip Code [illegible]

New Address:

[illegible]

[illegible] PA [illegible] Zip Code [illegible]

FEE: To obtain a [illegible] license reflecting the change of name and/or address, you must [illegible] your current license with this application and a $5.00 fee, check or money order payable to "Commonwealth of PA". Without the return of your license and the $5.00 fee, [illegible] will be issued.