FOR OFFICE USE ONLY

| Application fee 250 | Date fee paid (mo/day/yr) 2/25/13 | Receipt number 4242760 |
|---|---|---|
| License number 01072626A | License issuance date (mo/day/yr) 5/16/13 | |
| Permit fee | Date fee paid (mo/day/yr) | Receipt number |
| Permit number | Permit issuance date | |

## MEDICAL LICENSING BOARD OF INDIANA

## ADDENDUM INSTRUCTIONS

Addendum Instructions: Complete the addendums as instructed below. Please type or print your responses.

**Return the completed addendums, a printed copy of the UA application, payment and all supporting documentation to the Indiana Board.**

**Medical Licensing Board of Indiana**
**402 West Washington Street, Room W072**
**Indianapolis, IN 46204**

___ **Addendum 1**: The completion of this section of the form is **voluntary** and will **not** affect your application in any way.

___ **Addendum 2**: These questions must be completed by the applicant. Any "yes" responses to questions 1-10 will need additional documentation as explained in the form.

___ **Addendum 3:** ***This must be requested by all applicants.*** Follow the instructions to apply for and schedule your fingerprinting appointment. Failure to follow these instructions may delay processing and/or require additional fees to obtain the background check. For more information: http://www.in.gov/pla/3240.htm.

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Indiana Professional Licensing Agency

## ADDENDUM 1

## VOLUNTARY RACE / ETHNICITY / GENDER QUESTIONS**

This information is completely voluntary and will NOT affect your application in any way.

Gender: ☐ Male ☒ Female Race: White Ethnicity: White

** Note: This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Applicant Name: Cashman (Last) Casandra (First) Miller (Middle)

Social Security #: ___ Email Address: _

Mailing Address: _

City/State/Zip: _ Phone#: _

1/21/84

## ADDENDUM 2

### TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit? ☐ Yes ☒ No **If yes, an additional fee of $100 is required.**

### SPECIALITIES / BOARD CERTIFICATION

List specialty: Family Medicine

Board certification (list ABMS certification): Family Medicine

### ADDITIONAL QUESTIONS

**Answer the following questions. If your answer is "Yes" to any of these questions, explain fully in a signed, sworn and notarized affidavit, including all related details. Include the violation, location, date and disposition. If applicable, please submit copies of all court documents and/or arrest records. If malpractice, complete the "Malpractice Liability Claims Information" section of the Online Uniform Application for Physician State Licensure (UA) for each claim. Letters from attorneys or insurance companies are not accepted in lieu of your statement, but may be submitted with your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.**

__Yes X No 1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?

__Yes X No 2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (including Indiana) or country, or surrendered your license?

__Yes X No 3. Are you now being, or have you ever been treated for drug or alcohol abuse or addiction?

__Yes X No 4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?

5. Have you ever been convicted of, plead guilty or nolo contendere to, or are charges pending:

__Yes X No A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?

__Yes X No B. Any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines.)

__Yes X No 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?

__Yes X No 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?

__Yes X No 8. Have you ever had a malpractice judgment against you or settled any malpractice action?

__Yes X No 9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?

__Yes X No 10. Have you ever been disciplined by your employer while practicing as a physician or resigned in lieu of discipline?

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FEB 25 2013
Indiana Professional Licensing Agency

**I understand my failure to answer the above questions truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.**

Signature: Cashman redacted

Email Address: redacted Phone#: redacted

**Print Name:** Last: Cashman First: Casandra Middle: Miller

**Affidavit and Authorization for Release of Information**: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.



## Affidavit
## And
## Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of 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.

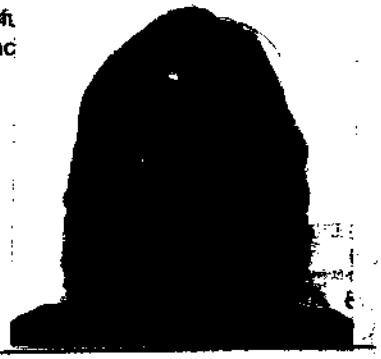
I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under 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 Board 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 Board 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 Board, its agents or representatives and any 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 of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully may result in denial, revocation, or other disciplinary sanction of my license or permit to practice.



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

Cashman
Applicant's Printed Last Name

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

Feb 12, 2013
Date of Signature

**NOTARY**

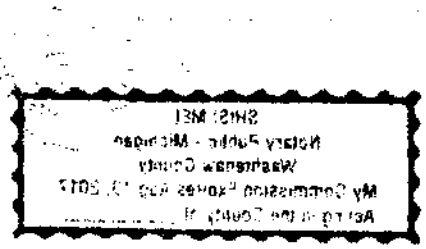
Dated 02/12/2013 Signed _____

State of Michigan County of Washtenaw

SUBSCRIBED AND SWORN TO before me this 12th day of Feb

My commission expires: Aug 19, 2017 (NOTARY PUBLIC SIGNATURE & SEAL) Acting in the County of Washtenaw

SHIRI MEI
Notary Public - Michigan
Washtenaw County
My Commission Expires Aug 19, 2017



# Uniform Application for Physician Licensure

UA Username: sydneycasandra
Date Submitted: 2/12/2013
FCVS Status: Applicant has an FCVS Packet

Printed By Applicant

**1. Name:** Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

**1. Full Name** (use no initials)



| | |
|---|---|
| Last Name | Cashman |
| First Name | Casandra |
| Middle Name | Miller |
| Suffix | |
| Maiden Name | |
| M.D. | [X] |
| D.O. | [ ] |

All other names used

| First | Middle | Last | Suffix |
|---|---|---|---|
| Casandra | Lynn | Miller | |
| Sydney | Casandra | Miller | |
| Sydney-Casandra | Miller | Cashman | |

**2. Address/Phone:** Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

**2. Address/Phone**

**Business**

[X] Public Access
[X] Mailing

Street
City
State/Province
Zip Code
Country USA
Telephone
Fax
Email
Alternate Phone

**Home**

[ ] Public Access
[ ] Mailing

Street
City
State/Province
Zip Code
Country USA
Telephone
Fax
Email
Alternate Phone

**3. Identification:** If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

**3. Identification**

| Date of Birth (mm/dd/yyyy) | Birth City | Birth State/Province | Birth Country |
|---|---|---|---|
| | Louisville | Kentucky | USA |

F
Gender | Social Security Number | NPI | Are you a U.S. Citizen? [X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 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. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

**4. Medical School:** List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

**4. Medical School**

1

| | |
|---|---|
| School Name | University of Louisville School of Medicine |
| Address | Health Sciences Center |
| City | Louisville |
| State/Province | KY |
| ZIP Code | 40292 |
| Country | USA |
| Attendance Dates | From (mm/yyyy) 08/2005 To (mm/yyyy) 05/2009 |
| Graduation Date | 5/1/2009 |
| Degree | MD |

**5. Fifth Pathway:** If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

**5. Fifth Pathway (if applicable)**

| | | | |
|---|---|---|---|
| Medical School Name | | | |
| Address | | | |
| City | | | |
| State/Province | | | |
| ZIP Code | | | |
| Country | | | |
| Attendance Dates | From (mm/yyyy) | To (mm/yyyy) | In Progress |
| Graduation Date | | | |
| Degree | | | |
| Institution name where rotations performed | | | |
| Address | | | |
| City | | | |
| State/Province | | | |
| ZIP Code | | | |
| Country | | | |
| Rotation Dates | From (mm/yyyy) | To (mm/yyyy) | In Progress |
| Certification Date | | | |

**6. Postgraduate Training:** List all postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to all postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

**6. Postgraduate Training**

1 **Hospital Name** Halifax Medical Center
**Hospital Address** 202 N Clyde Morris Blvd

**City** Daytona Beach
**State/Province** Florida
**ZIP Code** 32114
**Country** USA

**PGY: (e.g., 1, 2, 3, etc.)** [X] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

**Department/Specialty** Family Medicine

**From:** 07 /2009 **To:** 06 /2012 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]
Month Year Month Year

2 **Hospital Name** University of Michigan
**Hospital Address** 1500 e medical center drive

**City** ann arbor
**State/Province** Michigan
**ZIP Code** 48109
**Country** USA

**PGY: (e.g., 1, 2, 3, etc.)** [ ] **Internship** [ ] **Residency** [X] **Fellowship** [ ] **Research** [ ] **Other**

**Department/Specialty** Family Medicine (Women's Health)

**From:** 07 /2012 **To:** 06 /2013 **Successfully Completed?** [ ] **Yes** [ ] **No** **In Progress** [X]
Month Year Month Year

**7. Examination History:** If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

**7. Examination History**

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

| Examination | State | Most Recent Date taken(Month/Year) | Passed (P) or Failed (F) | | Number of attempts |
|---|---|---|---|---|---|
| USMLE Step 1 | | 06/2007 | [X] P | [ ] F | 1 |
| USMLE Step 2 | | 10/2008 | [X] P | [ ] F | 1 |
| USMLE Step2 CS | | 09/2008 | [X] P | [ ] F | 1 |
| USMLE Step 3 | | 03/2010 | [X] P | [ ] F | 1 |

**8. ECFMG:** If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

| 8. ECFMG (If applicable) | | |
|---|---|---|
| Certificate Number | Issue Date | Valid Through Date |

**9. State or Professional Licensure:** List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

**9. State Licensure**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | State/Province | FL | Practitioner Type (MD, DO, etc.) | OTHER | Type of License (Full, Temporary, etc.) | | |
| | License Number | TRN13483 | Status | Inactive | Issue Date | 4/1/2009 | |
| 2 | State/Province | FL | Practitioner Type (MD, DO, etc.) | MD | Type of License (Full, Temporary, etc.) | | |
| | License Number | MRN107604 | Status | Inactive | Issue Date | 7/1/2010 | |
| 3 | State/Province | MI | Practitioner Type (MD, DO, etc.) | MD | Type of License (Full, Temporary, etc.) | | |
| | License Number | 4301099902 | Status | Active | Issue Date | 1/1/2012 | |

**10. Chronology of Activities:** List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* 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 administrative duties.

**10. Chronology of Activities**

| Dates From/To | Practice/Employment |
|---|---|
| 1<br>From:<br>Month: 05<br>Year: 2009<br>To:<br>Month: 06<br>Year: 2009<br>In Progress ☐ | **Practice/Employment Name**<br>(or list non-working time as indicated above)<br>**Practice/Employment Address**<br>**City**<br>**State/Province**<br>**ZIP Code** **Country**<br>**Position and Department**<br>**Percent Clinical:** 0% **Percent Administrative:** 0%<br>**Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other** |

| Dates From/To | Practice/Employment |
|---|---|
| 2<br>From:<br>Month: 07<br>Year: 2009<br>To:<br>Month: 06<br>Year: 2012<br>In Progress ☐ | **Practice/Employment Name** Halifax Medical Center<br>(or list non-working time as indicated above)<br>**Practice/Employment Address** 201 N Clyde Morris Blvd<br>**City** Daytona Beach<br>**State/Province** Florida<br>**ZIP Code** 32114 **Country** USA<br>**Position and Department** resident-family medicine<br>**Percent Clinical:** 100% **Percent Administrative:** 0%<br>**Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other** |

3

From:

Month: 07
Year: 2012

To:

Month: 07
Year: 2012

In Progress ☐

Practice/Employment Name
(or list non-working time as indicated above)

Practice/Employment Address

City

State/Province

ZIP Code Country

Position and Department

Percent Clinical: 0% Percent Administrative: 0%

Employment ☐ Staff Privileges ☐ Affiliation ☐ Other

4

From:

Month: 07
Year: 2012

To:

Month:
Year:

In Progress ☒

Practice/Employment Name University of Michigan
(or list non-working time as indicated above)

Practice/Employment Address 1500 E Medical Center Drive

City Ann Arbor

State/Province Michigan

ZIP Code 48109 Country USA

Position and Department Fellow/Clinical Lecturer-OB/GYN and Family medicine

Percent Clinical: 100% Percent Administrative: 0%

Employment ☐ Staff Privileges ☐ Affiliation ☐ Other

**11. Malpractice:** List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. All fields are required to be answered. Please have your information available before reviewing this section. If you do not have any such claims or suits, please indicate so with, "I do not have any malpractice liability claim information."

**11. Malpractice Liability Claims Information**

**Name of patient involved:**

**In which state did the action take place?** **Case number (if applicable)**

**Which court?**
**(If private compromise or settled before initiation of civil action, state here)**

**Current status of claim:**

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

**Amount of judgement or settlement $** **Amount paid on your behalf $**

**Month and year of event precipitating claim:**

**Month and year of lawsuit:**

**Insurance carrier at time:**

**What is/or was your status?** ☐ Primary defendant ☐ Co-defendant ☐ Other

**Please provide specifics in reference to the adverse event including the allegations and your role in the event:**

# The University of Louisville

To all to whom these Letters shall come, Greeting:

The trustees of the University on the recommendation of the University faculty and by virtue of the authority vested in them have conferred on

## Casandra Miller Cashman

who has satisfactorily pursued the studies and passed the examinations required therefor the degree of

## Doctor of Medicine

with all the rights, privileges and honors pertaining thereto.

Granted at the University of Louisville in the Commonwealth of Kentucky on the Ninth day of May in the year Two Thousand Nine.



UNIVERSITY OF LOUISVILLE

Chair of the Board of Trustees

President of the University

State of Michigan
County of Washtenaw

On this 13 day of Feb 2013, I certify that the preceding/attached document is a true, exact, complete and unaltered photocopy made by Cassandra Miller Cashman

Affiant Signature

Subscribed and sworn to (or affirmed) before me this 13 day of Feb 2013 by Cassandra Miller Cashman

Notary Public Signature

MINAL B. KELKAR
NOTARY PUBLIC, STATE OF MI
COUNTY OF WASHTENAW
MY COMMISSION EXPIRES Jul 6, 2014
ACTING IN COUNTY OF Washtenaw

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

STEVEN H. HILFINGER
DIRECTOR

# VERIFICATION OF LICENSURE

## MICHIGAN BOARD OF MEDICINE

## VERIFICATION OF LICENSURE AS OF January 17, 2013

**NAME:** Casandra Miller Cashman **BIRTHDATE:**

**ADDRESS:** Dept of Family Medicine
L2003 Women's Health
Ann Arbor MI 481095239

**TYPE:** Medical Doctor **ORIGINAL DATE:** 01/17/2012

**LICENSE NUMBER:** 4301099902 **STATUS:** Active **EXPIRATION DATE:** 01/31/2016

**OBTAINED BY:** Examination

| EXAM DATE | EXAM TYPE | EXAM SCORE OR RESULT |
|---|---|---|

**DISCIPLINARY ACTION** NONE

**OPEN FORMAL COMPLAINTS** NONE

This license information was last updated on: 1/16/2013

Rick Scott
Governor

John H. Armstrong, MD, FACS
Surgeon General & Secretary

January 17, 2013

Indiana, Medical Licensing Board of
402 W Washington St, Room W066
Indianapolis, IN 46204

RE: License Certification for Casandra Miller Cashman

To Whom It May Concern:

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

| | |
|---|---|
| PROFESSION: | Medical Doctor |
| LICENSE NUMBER: | TRN13483 |
| ORIGINAL CERTIFICATION: | 04/29/2009 |
| EXPIRATION DATE: | 04/28/2011 |
| CURRENT STATUS OF LICENSE: | HOLDS OTHER LICENSE |
| AGENCY ACTION: | None |

This license information was last updated on: 01/17/2013

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

Rick Scott
Governor

John H. Armstrong, MD, FACS
Surgeon General & Secretary

January 17, 2013

Indiana, Medical Licensing Board of
402 W Washington St, Room W066
Indianapolis, IN 46204

RE: License Certification for Casandra Miller Cashman

To Whom It May Concern:

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

| | |
|---|---|
| PROFESSION: | Medical Doctor |
| LICENSE NUMBER: | ME107804 |
| ORIGINAL CERTIFICATION: | 07/23/2010 |
| EXPIRATION DATE: | 01/31/2014 |
| CURRENT STATUS OF LICENSE: | VOLUNTARY RELINQUISHMENT |
| AGENCY ACTION: | None |

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

HALIFAX
HEALTH

February 12, 2013

Indiana Professional Licensing Agency
Medical Licensing Board
402 West Washington Street, Room W072
Indianapolis, IN 46204

***Re: Casandra Cashman, MD***

To Whom It May Concern:

Dr. Cashman began her Family Medicine residency here on July 1, 2009, and successfully completed the program on June 30, 2012.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Edwin E Prevatte

Edwin Prevatte, M.D.
Program Director
Halifax Health Medical Center
Family Medicine Residency Program

EP/ll



FAMILY MEDICINE
RESIDENCY PROGRAM
201 N. CLYDE MORRIS BLVD.
DAYTONA BEACH, FL 32114
SUITE 200
T: 386.254.4167
F: 386.258.4867

halifaxhealth.org

*Affiliated with the University of South Florida College of Medicine*




# Medical Professional Information Profile

*This report provides credentialing information for*

Name: **Casandra Miller Cashman**

Social Security: Number:

Date of Birth:

FID#: **215425612**

Recipient: **IN - Medical Licensing Board of Indiana**

## ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional 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.

NOTICE: All documents bearing an original Official FCVS seal are certified 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.

This FCVS medical professional information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

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11

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

# Credentials Analysis Summary Report

**Note:** *Your board may wish to review the unresolved items below marked by an "X"*
*Please review the Credentials Analysis report for further details on the unresolved items*

Medical Professional Name: **Casandra Miller Cashman**
Date of Birth:
Social Security Number:
FID: **215425612**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

University of Louisville School of Medicine
1. Medical Education Form
2. Medical Education Transcript
3. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Halifax Health Medical Center
1. GME Form
2. GME Completion Certificate

University of Michigan Health System
1. GME Form

VI. Licensure Examination History

A. FSMB Exams

End of report for: Casandra Miller Cashman

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Medical Professional Profile

## Table of Contents




400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

**Medical Professional Information Profile**

# Section I

FCVS Reports

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-3000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Medical Professional Information Report

## Identity

| | |
|---|---|
| Medical Professional Name: | **Casandra Miller Cashman** |
| | Documentation: Photocopy of Name Change Document and Translation if not in English |
| Variation of Name: | **Sydney Casandra Miller** |
| | Documentation: Photocopy of Name Change Document and Translation if not in English |
| | **Sydney-Casandra Miller Cashman** |
| | Documentation: Photocopy of Marriage Certificate and Translation if not in English |
| | **Casandra Lynn Miller** |
| | Documentation: Certified Birth Certificate |
| Gender: | Female |
| Date of Birth: | |
| Place of Birth: | Jefferson County, KY, UNITED STATES |
| Social Security Number: | |
| FID: | 215425612 |
| Physical Description: | Height: 5 ft. 4 in. |
| | Weight: 135 lbs. |
| | Eye Color: Gray |
| | Hair Color: Blond |

## Contact Information

| | |
|---|---|
| Mailing Address: | |
| | UNITED STATES |
| Permanent Address: | |
| | UNITED STATES |
| Telephone Numbers: | Primary: |
| | Secondary: N/A |
| | Fax: N/A |
| | Other: N/A |

## Premedical Education

*(Provided by Applicant. Not verified with the primary source.)*

**Institution:** **Wells College**
Address: Aurora, NY
UNITED STATES
Dates of Attendance: 08/--/2000 To 05/--/2003
Degree Conferred/Issued: Bachelor of Arts

## ECFMG

There are none identified or not applicable.

## Medical Education

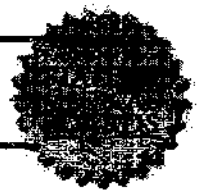
**Medical School:** **University of Louisville School of Medicine**
Address: Abell Administration Center
323 E Chestnut St
Louisville, KY 40292
UNITED STATES

Dates of Attendance: 08/15/2005 to 04/24/2009
Date Certificate Issued: 05/09/2009
Degree Conferred/Issued: Doctor of Medicine

**Unusual Circumstances**
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

## Fifth Pathway

There are none identified or not applicable.



## Graduate Medical Education

**Institution:** **Halifax Health Medical Center**
Address: PO Box 2830
303 North Clyde Morris Boulevard
Daytona Beach, FL 32120-2830
UNITED STATES

Training Level: 1
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/2009 To 06/30/2010
Completed Successfully: Yes
Accreditation: ACGME

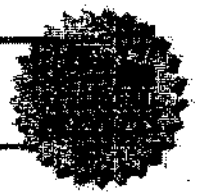
Training Level: 2
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/2010 To 06/30/2011
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 3
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/2011 To 06/30/2012
Completed Successfully: Yes
Accreditation: ACGME

**Unusual Circumstances**
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Medical Professional Information Report



**Institution:** **University of Michigan Health System**
Address: L4510 Womens Hospital
1500 East Medical Center Drive
Ann Arbor, MI 48109-0276
UNITED STATES

Training Level: 4
Program Type: Fellowship
Specialty: Womens Health Fellowship
Dates of Attendance: 07/09/2012 To 06/30/2013
Completed Successfully: In Progress
Accreditation: None of these

**Unusual Circumstances**
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

## Licensure Examinations

| | | |
|---|---|---|
| FSMB Transcript USMLE Step 1 | Date: 6/2007 | Passed the Exam |
| FSMB Transcript USMLE Step 2 CK | Date: 10/2008 | Passed the Exam |
| FSMB Transcript USMLE Step 2 CS | Date: 9/2008 | Passed the Exam |
| FSMB Transcript USMLE Step 3 | Date: 3/2010 | Passed the Exam |

## ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

## Board Action

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

**End of report for Casandra Miller Cashman FID: 215425612**

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

# Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

## Medical Professional Identification

| | |
|---|---|
| Medical Professional Name: | **Casandra Miller Cashman** |
| Date of Birth: | |
| Social Security Number: | |
| FID: | **215425612** |

## Omissions

There are no omissions identified.

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## Discrepancies

There are no discrepancies identified.

## Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Casandra Miller Cashman

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Chronology of Activities

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical professional applicant.

Medical Professional Name: **Casandra Miller Cashman**
Date of Birth:
Social Security Number:
FID#: **215425612**

| Start Date | End Date | Activity | Location | Overlap Explanation | Program Length Explanation |
|---|---|---|---|---|---|
| 8/2005 | 05/2009 | Medical Education Record | University of Louisville School of Medicine,Abell Administration Center Louisville, KY 40292 UNITED STATES | | |
| 7/2009 | 06/2012 | GME Record | Halifax Health Medical Center,PO Box 2830 Daytona Beach, FL 32120-2830 UNITED STATES | | |
| 7/2012 | 06/2013 | GME Record | University of Michigan Health System,L4510 Womens Hospital Ann Arbor, MI 48109-0276 UNITED STATES | | |

End of report for Casandra Miller Cashman

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# Section II

FSMB and Other Reports

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-3800 | FAX(817)868-5099

FPDC | FEDERATION PHYSICIAN DATA CENTER

**Board Action Clearance Report**

April 05, 2013

Attn: Tracy Bevers
FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: April 05, 2013
FSMB Batch Number: BQ2233349

The following is a report of the search results from the Board Action Data Bank as of April 05, 2013 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of April 05, 2013

| Name | DOB | School | Yr/Grad | Provider ID |
|---|---|---|---|---|
| Casandra Miller Cashman | 01/21/1984 | 018020 | 2009 | 269248 |

**License History**

| Licensing Entity |
|---|
| FLORIDA |
| MICHIGAN |

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# ABMS Verification of Certification



As of: **04/05/2013**
Medical Professional Name: **Casandra Cashman**
Date of Birth:
Year of Graduation: **2009 (Doctor of Medicine)**
ABMSUID#: **994792**

## Certification

**Certification:**

Board: Family Practice
Specialty: Family Practice
Status: ACT
Initial Certification: 07/01/2012

End of report for Casandra Cashman

All certification information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

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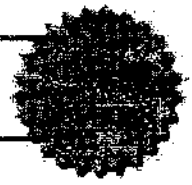


# Section III

Identity

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5959

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

# 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 me 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.

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.

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.

While the FSMB will only use collected personal information for the purposes described on our website and in the FCVS application materials, the FSMB has no control over the entities to which an applicant authorizes the release of FCVS materials. Such entities may include state medical boards, state osteopathic boards, and other entities that may be subject to state and federal public information or open records laws, which might require the release of certain FCVS packet information to the public upon request.

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

Cashman,
Cassandra Miller
Applicant's Printed Last Name

2.4.2013
Date of Signature (must correspond to date of notarization)

State of Michigan, County of Washtenaw

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 4th day of Feb, 2013.

SHSH MEI
Notary Public - Michigan
Washtenaw County
My Commission Expires Aug 19, 2017
Acting in the County of Washtenaw

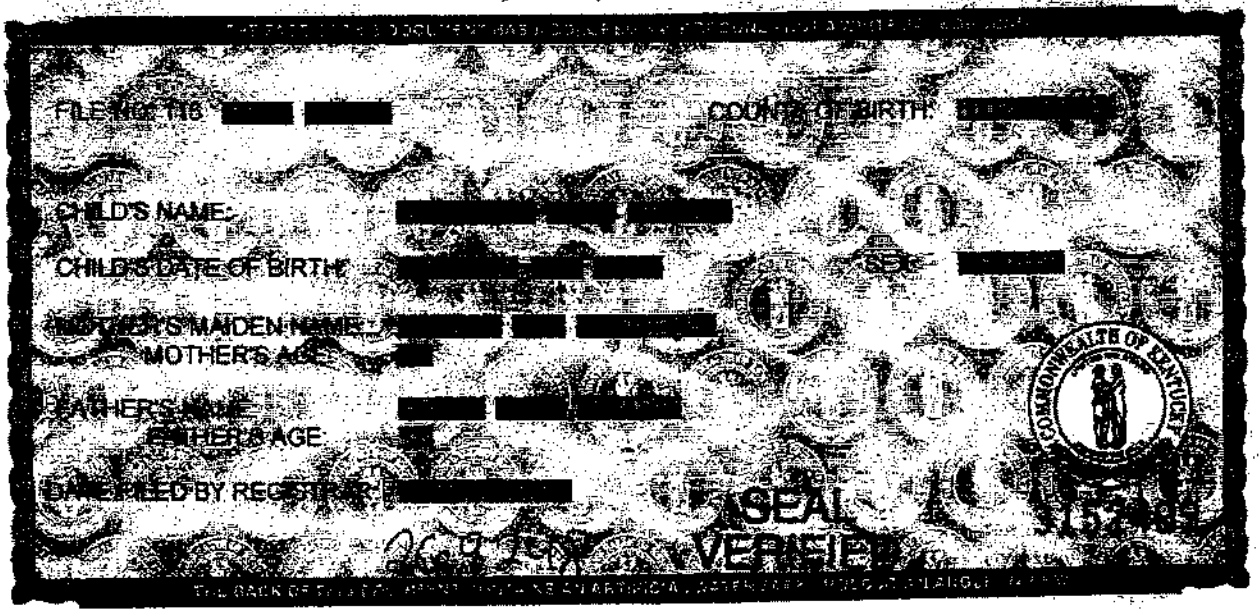
Notary Public Signature:

My Notary Commission Expires: Aug 19, 2017

269248 269248 215425812

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

# Certified Record of Birth
# Commonwealth of Kentucky
# Cabinet For Health and Family Services




This record certifies that the above birth occurred on the date and place shown. The original certificate of birth is on file with the Cabinet for Health and Family Services, Office of Vital Statistics, 275 East Main Street, Frankfort, Kentucky 40621-0001.

Paul E. Royce
State Registrar

DATE ISSUED: 01/23/2013

IF YOU HAVE QUESTIONS REGARDING THIS INFORMATION, YOU MUST RETURN THE RECORD WITHIN 30 DAYS ALONG WITH THIS NOTICE. PLEASE INCLUDE THE TELEPHONE NUMBER WHERE YOU MAY BE REACHED BETWEEN THE HOURS OF 8:00 A.M. AND 4:30 P.M. YOU MAY ALSO CONTACT THIS OFFICE AT 502-564-4212 MONDAY THROUGH FRIDAY. COPIES OF BIRTH RECORDS OF MORE THAN ONE PERSON MAY BE MAILED SEPARATELY.

CPC(S): 1
CERTIFICATE HOLDER: CASANDRA LYNN MILLER

CASANDRA CASHMAN
2890 BARCLAY WAY
ANN ARBOR MI 48105

AOC-296 Doc. Code: OCN
Rev. 4-04
Page 1 of 1
Commonwealth of Kentucky
Court of Justice www.courts.ky.gov
KRS Chapter 401

**NAME CHANGE ORDER**

Case No. 08-P-006067
Court
Division
County

IN RE: CHANGE OF NAME FOR SYDNEY CASANDRA MILLER CASHMAN

Petitioner(s): SYDNEY CASANDRA MILLER CASHMAN

DAVID L. NICHOLSON, CLERK
DEC 22 2008
BY DEPUTY CLERK

[ ] living parents [ ] surviving parent [ ] guardian of the above-captioned minor; or [X] above-captioned adult, having filed a petition for name change and the Court having held a hearing on the matter, the Court makes the following

FINDINGS OF FACT:

1. The original name is SYDNEY CASANDRA MILLER CASHMAN.
2. The desired name change is CASANDRA MILLER CASHMAN.
3. The minor, being less than 18 years old, or the adult, being at least 18 years old, is 24 years of age; date of birth being __ _____, 2XXX; and birthplace being LOUISVILLE, KY.
4. The minor/adult is currently a resident of the county in which this petition is filed, his/her address being 1416 CHRISTY AVENUE LOUISVILLE, KY 40204
5. For a minor's petition only:
   a. The name of the minor's father, if known, is _____.
   b. The name of the minor's mother, if known, is _____.

Based on the above findings of fact, IT IS HEREBY ORDERED that the name is changed.

DAVID L. NICHOLSON, CLERK
DEC 2008
BY DEPUTY CLERK

Date: _____

Anne Haynie
Signature of Judge

A COPY
ATTEST: DAVID L. NICHOLSON, CLERK
JEFFERSON CIRCUIT COURT
LOUISVILLE, KENTUCKY
BY D.C.

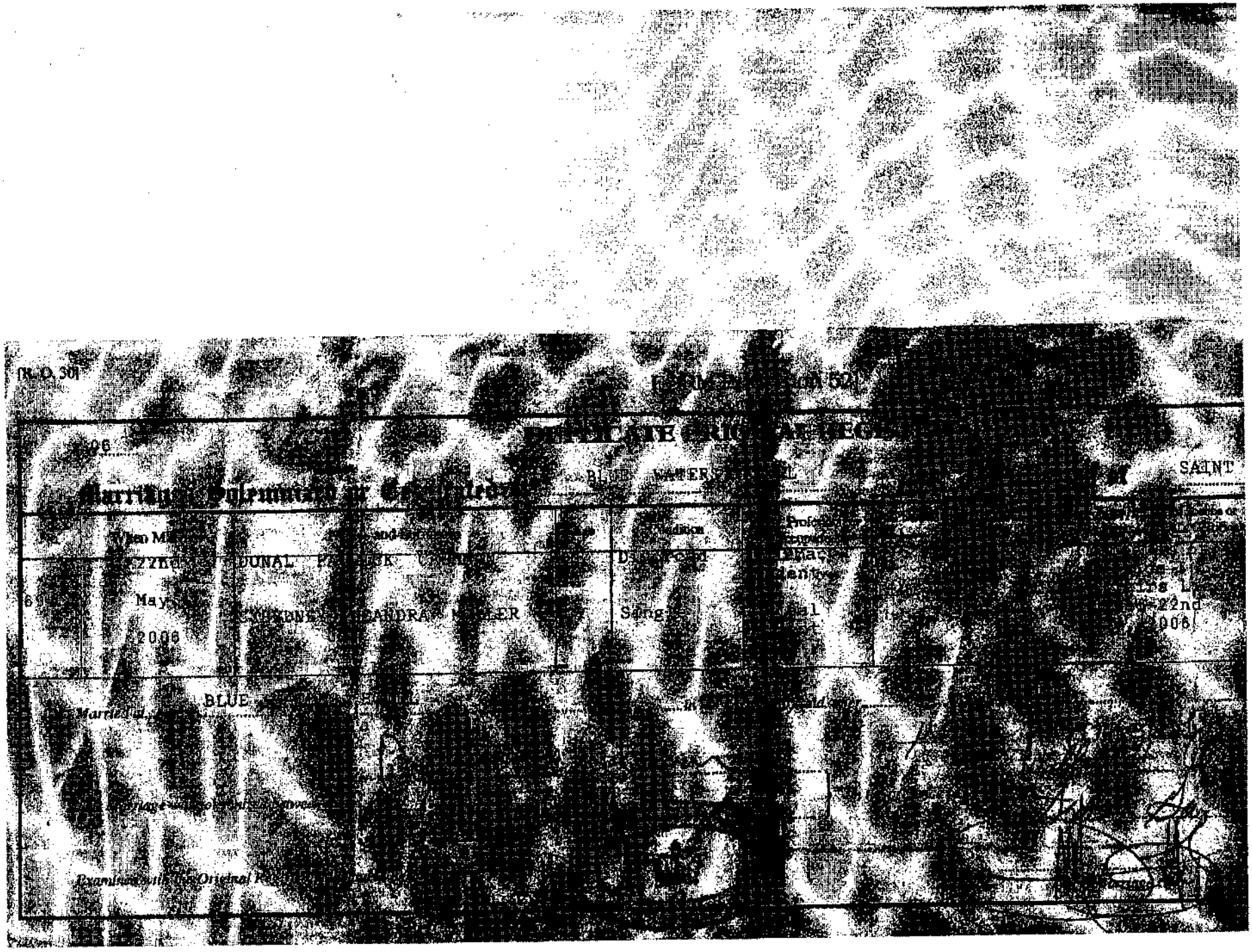
Attorney Name and Address (*If any*): _____

**NOTICE TO ADULT PETITIONER:**

Pursuant to KRS 186.540, if you have applied for or are in receipt of a Kentucky driver's license, you have ten (10) days after entry of this Order to apply to circuit clerk in your county of residence for the issuance of a corrected license.

**NOTICE TO CLERK:**

Pursuant to KRS 401.040, if a name change is Ordered, send a certified copy of this Order to the county clerk for recording and instruct the petitioner to pay the county clerk's recording fee.



# Section IV

Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Verification of Medical Education



## Instruction to the Dean

Please complete both pages of this form, sign, date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

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 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).

**Institution Name:** University of Louisville School of Medicine

**Address Line 1:**
University of Louisville School of Medicine

**Address Line 2:**

**City:** Louisville **State/Province:** KY **Zip Code (Postal Code):** 40292
**Country:** US

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: 3 tyrs.
Credential/degree presented by the applicant for admission to your medical school: Bachelor's

**Enrollment and Participation:** Our records indicate that Cashman, Cassandra Miller
(typeprint individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 156 weeks of medical education on the following dates: From: 8 15 05 (Month Day Year) To: 4 24 09 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 5 9 09 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

**Attestation**

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

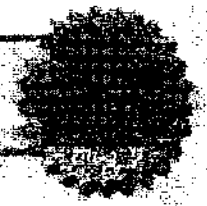
SEAL VERIFIED

Name: Sherri Cheek
Signature:
Title: Sr. Academic Coordinator
Date of Signature: 3 6 13 Phone: 502-852-6183
Fax: 502-852-5871 Email: Sherry01@louisville.edu

269248 269248 2276 215625612

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Verification of Medical Education





## Unusual Circumstances

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

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

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

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? ___ YES ___ NO

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

| | | |
|---|---|---|
| Academic Probation | From (Mo/Yr)___/___ | To (Mo/Yr)___/___ |
| Probation for unprofessional conduct/behavioral | From (Mo/Yr)___/___ | To (Mo/Yr)___/___ |
| Probation for other reason | From (Mo/Yr)___/___ | To (Mo/Yr)___/___ |

Please specify a 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? ___ 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 for behavioral reasons or an investigation by the medical school or parent university? ___ YES ___ NO

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

___ YES ___ NO

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 incompetence, disciplinary problems, or any other reason?

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

269248 269248 2154256132

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

# Applicant Reported Unusual Circumstances



## Medical School

**Medical Professional Name: Casandra Miller Cashman**

**University of Louisville School of Medicine**

## Unusual Circumstances

| | | |
|---|---|---|
| Did you have any interruption(s) or extension(s) in your medical education? | Yes | **No** |
| Were you ever placed on probation? | Yes | **No** |
| Were you ever disciplined or placed under investigation? | Yes | **No** |
| Were any negative reports for behavioral reasons ever filed by instructors? | Yes | **No** |
| Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason? | Yes | **No** |

End of report for Casandra Miller Cashman

**PROVIDED BY APPLICANT**

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

# The University of Louisville

To all to whom these Letters shall come, Greeting:

The trustees of the University on the recommendation of the University faculty and by virtue of the authority vested in them have conferred on

**Cassandra Miller Cashman**

who has satisfactorily pursued the studies and passed the examinations required therefor the degree of

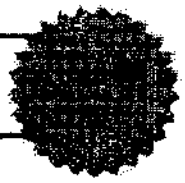
## Doctor of Medicine

with all the rights, privileges and honors pertaining thereto.

Granted at the University of Louisville in the Commonwealth of Kentucky on the Ninth day of May in the year Two Thousand Nine.

SEAL VERIFIED

Office of Medical Student Affairs
School of Medicine
University of Louisville
Louisville, KY 40292



# Section V

Graduate Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5077

Federation of STATE MEDICAL BOARDS

**Federation Credentials Verification Service (FCVS)**

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5008

## Verification of Graduate Medical Education

Institution: Halifax Health Medical Center
Attention: FAMILY PRACTICE
Specialty: Family Practice
Affiliated University: _____
Address: Daytona Beach, FL

**Verification For:**

Name: Cashman, Casandra Miller
DOB:
Individual's Name on Record (if different from above): _____

**Program Participation:**

Important:
Report incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (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/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

**Training Level: 1** (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine
From: 07/01/2009 To: 06/30/2010
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

**Training Level: 2** (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine
From: 07/01/2010 To: 06/30/2011
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

**Training Level: 3** (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Family Medicine
From: 07/01/2011 To: 06/30/2012
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

**Unusual Circumstances:**

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. 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:**

_____
_____

**Certification:**

Affix your institutional seal in this space. If no seal is available, you must have this certified

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Edwin E. Prevatte, MD
Signature: Edwin E. Prevatte, MD
Title of Signatory: Program Director
Date of Signature: 02/26/13
Tel: 386-254-4167 Fax: 386-258-4967 E-Mail: residency.coordinator@halifax.org

Rev. 02/21/2013

FCVS ID: 269248 FID: 215425612 CODE: 104321

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Applicant Reported Unusual Circumstances



## Graduate Medical Education

**Medical Professional Name: Casandra Miller Cashman**
**Halifax Health Medical Center**
**Family Practice**

## Unusual Circumstances

| | | |
|---|---|---|
| Did you have any interruption(s) or extension(s) in your medical education? | Yes | **No** |
| Were you ever placed on probation? | Yes | **No** |
| Were you ever disciplined or placed under investigation? | Yes | **No** |
| Were any negative reports for behavioral reasons ever filed by instructors? | Yes | **No** |
| Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason? | Yes | **No** |

End of report for Casandra Miller Cashman

**PROVIDED BY APPLICANT**

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

*The Board of Commissioners of Halifax Health*

takes pride in announcing

# *Casandra Miller Cashman, MD*

has honorably served as a
Resident Physician in Family Medicine
from

*July 1, 2009 to June 30, 2012*

and has successfully completed all requirements of
**Halifax Health - Family Medicine Residency Program**

In witness, we hereby affix our signatures and seal this
28rd day of June 2012, Daytona Beach, Florida

HALIFAX HEALTH

Edwin E. Pinero

Edwin Pinero, MD, Director, Family Medicine Residency Program

John Duncan

John Duncan, MD, Director, Sports Medicine Fellowship

Federation of STATE MEDICAL BOARDS

**Federation Credentials Verification Service (FCVS)**

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

## Verification of Graduate Medical Education

Institution: University of Michigan Health System

Attention: Program Director

Specialty: Womens Health Fellowship

Affiliated University: University of Michigan

Address: Ann Arbor, MI

**Verification For:**

Name: Cashman, Casandra Miller

DOB: !

Individual's Name on Record (If different from above): _____

**Program Participation:**

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (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/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

**Training Level:** 4 (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☒ Fellowship ☐ Research

**Specialty/Subspecialty:** Women's Health

**From:** 07/09/2012 **To:** 06/30/2013

**Successfully Completed?:** ☐ Yes ☐ No ☒ In Progress

**Accredited by:** ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☒ None of these

**Training Level:** _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

**Specialty/Subspecialty:** _____

**From:** / / **To:** / /

**Successfully Completed?:** ☐ Yes ☐ No ☐ In Progress

**Accredited by:** ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

**Training Level:** _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

**Specialty/Subspecialty:** _____

**From:** / / **To:** / /

**Successfully Completed?:** ☐ Yes ☐ No ☐ In Progress

**Accredited by:** ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

**Unusual Circumstances:**

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. 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:**

_____

_____

**Certification:**

Affix your institutional seal in this space. If no seal is available, you must have this certified

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Carrie Bell, MD

Signature: Carrie Bell, MD

Title of Signatory: Program Director (e.g., Program Director)

Date of Signature: 04/02/2013

Tel: 734 615-3773 Fax: 734 232-6020 E-Mail: cariebe@umich.edu

Rev. 04/02/2013

FCVS ID: 269248 FID: 215425612 CODE: 119487

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Applicant Reported Unusual Circumstances



## Graduate Medical Education

**Medical Professional Name: Casandra Miller Cashman**
**University of Michigan Health System**
**Womens Health Fellowship**

## Unusual Circumstances

| | | |
|---|---|---|
| Did you have any interruption(s) or extension(s) in your medical education? | Yes | **No** |
| Were you ever placed on probation? | Yes | **No** |
| Were you ever disciplined or placed under investigation? | Yes | **No** |
| Were any negative reports for behavioral reasons ever filed by instructors? | Yes | **No** |
| Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason? | Yes | **No** |

End of report for Casandra Miller Cashman

**PROVIDED BY APPLICANT**

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