STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

1-7
12-25-62
1/24/90

PRELIMINARY EDUCATION FORM

My name IN FULL is GLOVER (LAST) KATHLEEN (FIRST) — (MIDDLE)

High School or Equivalent:
GLENVILLE (SCHOOL NAME) Cleveland (CITY) Ohio (STATE) (COUNTRY)
9/64 (FROM (DATE)) 6/67 (TO (DATE)) DIPLOMA. (DEGREE)

Undergraduate College or Equivalent:
PURDUE UNIV (SCHOOL NAME) WEST LAFAYETTE (CITY) IND (STATE) USA (COUNTRY)
9/67 (FROM (DATE)) 6/75 (TO (DATE)) BA (DEGREE)

7-9-67
2/12/90

— (SCHOOL NAME) (CITY) (STATE) (COUNTRY)
— (FROM (DATE)) — (TO (DATE)) (DEGREE)

RAB

Medical School of Graduation:
WRIGHT STATE U. FAIRBORN, OHIO USA (SCHOOL NAME) (CITY) (STATE) (COUNTRY)
9/83 (FROM (DATE)) 6/88 (TO (DATE)) M.D. (DEGREE)

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: _____

DATE ISSUED: _____

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

MAY - 8 1990

_____
Entrance Examiner

_____
Secretary

APP-SENT 5/15/89 picked up new app 11/19/90

STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

PLEASE TYPE OR PRINT CLEARLY

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

NAME: GLOVER (LAST (Surname)) KATHLEEN (FIRST) — (MIDDLE) — (SUFFIX (Jr., II))

ADDRESS: 626 OMAR CIRCLE (STREET & NUMBER) YELLOW SPR (CITY) OHIO (STATE) 45387 (ZIP) GREENE (COUNTRY)

TELEPHONE: BUSINESS: (513) 220-2010 (AREA CODE & NUMBER) HOME: (513) 767-7606 (AREA CODE & NUMBER)

BIRTH DATE: 7/5/49 (MO/DAY/YR) BIRTH PLACE: CLEVELAND (CITY), OHIO (STATE) USA (COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: WRIGHT STATE UNIVERSITY (SCHOOL NAME) Colonel Glenn DR (STREET ADDRESS) FAIRBORN (CITY) OHIO (STATE) USA (COUNTRY)

9/ /83 (FROM (date)) 6/ /88 (TO (date)) M.D (DEGREE RECEIVED) 6/12/88 (DATE RECEIVED)

OTHER MEDICAL SCHOOLS ATTENDED: (IF "NONE" ENTER "NONE") NONE (SCHOOL NAME) (STREET ADDRESS) (CITY) (STATE) (COUNTRY)

/ / (FROM (date)) / / (TO (date)) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

(SCHOOL NAME) (STREET ADDRESS) (CITY) (STATE) (COUNTRY)

/ / (FROM (date)) / / (TO (date)) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

E.C.F.M.G. CERTIFICATE: YES _____ NO ✓ NUMBER _____ DATE ISSUED / /

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: (IF "NONE", ENTER "NONE") NONE (HOSPITAL OR INSTITUTION) AFFILIATED WITH: (NAME OF MEDICAL SCHOOL)

ADDRESS: (STREET & NUMBER) (CITY) (STATE) (ZIP) DATE: / / (FROM) / / (TO)

QUALIFYING EXAM TAKEN: DATE: / /

POSTGRADUATE TRAINING

LIST ALL POSTGRADUATE TRAINING (INTERNSHIP, RESIDENCY OR CLINICAL FELLOWSHIP), UNDERTAKEN IN THE U.S. OR CANADA. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

HOSPITAL: WRIGHT STATE INTERNAL MEDICINE (NAME) Miami Valley Hospital / Wyoming St DAYTON, OHIO (STREET ADDRESS) (CITY) (STATE)
POSITION: INTERNAL MEDICINE RESIDENT (DEPARTMENT: Internal MED) DATE: 7/1/88 (FROM) 6/30/89 (TO)

HOSPITAL: (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: (DEPARTMENT:) DATE: / / (FROM) / / (TO)

HOSPITAL: (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: (DEPARTMENT:) DATE: / / (FROM) / / (TO)

HOSPITAL: (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: (DEPARTMENT:) DATE: / / (FROM) / / (TO)

MAY - 8 1989

LICENSES IN OTHER COUNTRIES

LIST ALL FOREIGN COUNTRIES IN WHICH YOU HOLD OR HAVE HELD A FULL RIGHT TO PRACTICE MEDICINE AND SURGERY. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

COUNTRY: none ISSUE DATE: / / LICENSE # CURRENT: YES NO

COUNTRY ISSUE DATE: / / LICENSE # CURRENT: YES NO

LICENSES IN THE UNITED STATES

LIST ALL STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY. INDICATE THE LICENSE NUMBER, DATE OF ISSUANCE, WHETHER OR NOT THE LICENSE IS CURRENT, AND THE BASIS OF LICENSURE (E.G., FLEX EXAM, ENDORSEMENT OF OTHER STATE LICENSE, ENDORSEMENT OF DIPLOMATE STATUS, ETC.) IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: none ISSUE DATE: / / LICENSE #: CURRENT: YES NO

BASIS OF LICENSURE:

STATE: ISSUE DATE: / / LICENSE #: CURRENT: YES NO

BASIS OF LICENSURE:

STATE: ISSUE DATE: / / LICENSE #: CURRENT: YES NO

BASIS OF LICENSURE:

STATE BOARD OR FLEX EXAMINATIONS TAKEN

LIST EACH AND EVERY STATE BOARD OR FLEX EXAM WHICH YOU HAVE TAKEN WHETHER IN OHIO OR ANY OTHER STATE, TERRITORY OR PROVINCE. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

PART I STATE: Ohio DATE TAKEN: 6-86 PASS: ✓ FAIL: FULL ( ) PARTIAL ( )

PART II STATE: Ohio DATE TAKEN: 9-87 PASS: ✓ FAIL: FULL ( ) PARTIAL ( )

PART III STATE: Ohio DATE TAKEN: 3-89 PASS: ✓ FAIL: FULL ( ) PARTIAL ( )

STATE: DATE TAKEN: PASS: FAIL: FULL ( ) PARTIAL ( )

ADDITIONAL ELIGIBILITY INFORMATION -ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? YES ✓ NO DATE / /

DIPLOMATE OF THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS? YES NO ✓ DATE / /

A LICENTIATE OF THE MEDICAL COUNSEL OF CANADA? YES NO ✓ DATE / /

A U.S. CITIZEN? YES ✓ NO BASIS OF CITIZENSHIP BIRTH DATE: 7/5/49

A GRADUATE OF A MEXICAN MEDICAL SCHOOL? YES ✓ NO DATE / /

DEGREE OBTAINED (CHECK ONLY ONE): ACTA TITULO MEDICO CIRUJANO

HAVE YOU ACHIEVED A SCORE OF AT LEAST TWO HUNDRED THIRTY (230) ON THE TEST OF SPOKEN ENGLISH OF THE EDUCATIONAL TESTING SERVICE AS REQUIRED UNDER SECTION 4731.09, O.R.C.?

YES NO DID NOT TAKE TEST

OHIO RESIDENT AT THE TIME OF ADMISSION TO MEDICAL SCHOOL? YES ✓ NO

IF YES, GIVE FULL ADDRESS AT THAT TIME:

3303 CLARENDON Cleve HTS, Ohio 44118

STREET ADDRESS CITY STATE ZIP

CERTIFICATION

I, Kathleen Brown MD, HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING SCREENING FORM; THAT THE STATEMENTS THEREIN ARE STRICTLY TRUE IN EVERY RESPECT AND THAT I HAVE READ AND UNDERSTAND THIS CERTIFICATION.

Kathleen Brown MD 5-4-89

SIGNATURE DATE

RETURN TO: STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

FLEX

APPLICATION FOR MEDICAL & OSTEOPATHIC LICENSURE

DC

UMA rec. Miami Valley 1-31-90

State Medical Board of Ohio
77 S. High St.
17th Floor
Columbus, Ohio 43215

ALL RESPONSES MUST BE TYPED

1. SOCIAL SECURITY NUMBER [redacted]

2. FULL NAME (Use no initials)

LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
GLOVER	KATHLEEN	NONE	NONE

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

LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
GLOVER	KATHLEEN		

4. ALTERNATE NAMES (IF "NONE" ENTER "NONE")

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

5. CURRENT ADDRESS

STREET NUMBER & NAME: 626 OMAR CIRCLE

CITY	STATE	ZIP CODE	COUNTRY
YELLOW SPRINGS	OHIO	45387	u.s.a. USA

6. PHYSICAL DESCRIPTION

HEIGHT	WEIGHT	HAIR COLOR	COLOR OF EYES	IDENTIFYING MARKS
5'8"	200lbs.	BROWN	BROWN	NONE

7. SEX MALE [ ] FEMALE [XX] FOR STATISTICS ONLY (Optional)

8. CITY IN OHIO WHERE YOU PLAN TO PRACTICE: GREENE AND MONTGOMERY COUNTIES
(CITY OR COUNTY)

PLANS OF PRACTICE: GENERAL MEDICINE

9. SPECIALTY BOARDS (USA, Canada and foreign countries)

NAME OF SPECIALTY BOARD	BOARD CERTIFIED YES	BOARD CERTIFIED NO	YEAR CERTIFIED	COUNTRY
NONE	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		

STATE MEDICAL BOARD OF OHIO
90 JAN 22 PM 4:31

FOR OFFICE USE ONLY 34 DC 35 FLEX

1-7
12-15-62
1-24-90
165.00 rec 165

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

RESUME

DC

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. I in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

GLOVER

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
a. 6 / 88 (month / year) TO 7 / 88 (month / year)	Hospital/University/Other VACATION 626 OMAR CIRCLE YELLOW SPRINGS OHIO 45387 Street Address City/State Zip	N/A	--	--
b. 7 / 88 (month / year) TO 7 / 89 (month / year)	WRIGHT STATE UNIVERSITY INTERNAL MEDICINE PROGRAM Hospital/University/Other 1 WYOMING STREET Dayton, Ohio 45435 Street Address City/State Zip	INTERN	100%	
c. 7 / 89 (month / year) TO present 1 / 90 (month / year)	MORRIS BROWN AND ASSOC Hospital/University/Other 128 W. First St Dayton, Ohio 45402 Street Address City/State Zip	part-time TUTEE IN OFFICE	100%	
d. 7 / ~~88~~ 89 (month / year) TO 6 / 90 (month / year)	ON LEAVE FROM WRIGHT STATE INTERNAL MED. RESIDENCY Hospital/University/Other 626 OMAR CIRCLE Yellow Springs, Oh 45387 Street Address City/State Zip	PROGRAM N/A	N/A	N/
e. (month / year) TO (month / year)	Hospital/University/Other Street Address City/State Zip			

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
f. month year TO month year	Hospital/University/Other Street Address City/State Zip			
g. month year TO month year	Hospital/University/Other Street Address City/State Zip			
h. month year TO month year	Hospital/University/Other Street Address City/State Zip			
i. month year TO month year	Hospital/University/Other Street Address City/State Zip			
j. month year TO month year	Hospital/University/other Street Address City/State Zip			
k. month year TO month year	Hospital/University/Other Street Address City/State Zip			
l. month year TO month year	Hospital/University/Other Street Address City/State Zip			

RESUME

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. I in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

GLOVER

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
a. 6 / 88 (month / year) TO 7 / 88 (month / year)	Hospital/University/(Other) VACATION 626 OMAR CIRCLE YELLOW SPRINGS OHIO 45387 Street Address City/State Zip	N/A	--	--
b. 7 / 88 (month / year) TO 7 / 89 (month / year)	WRIGHT STATE UNIVERSITY INTERNAL MEDICINE PROGRAM Hospital/(University)/Other 1 WYOMING STREET Dayton, Ohio 45435 Street Address City/State Zip	INTERN	100%	
c. 7 / 89 (month / year) TO present 1 / 90 (month / year)	MORRIS BROWN AND ASSOC Hospital/University/(Other) 128 W. First St Dayton, Ohio 45402 Street Address City/State Zip	part-time TUTEE IN OFFICE	100%	
d. month / year TO month / year	Hospital/University/Other Street Address City/State Zip			
e. month / year TO month / year	Hospital/University/Other Street Address City/State Zip			

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
f. month year TO month year	Hospital/University/Other Street Address City/State Zip			
g. month year TO month year	Hospital/University/Other Street Address City/State Zip			
h. month year TO month year	Hospital/University/Other Street Address City/State Zip			
i. month year TO month year	Hospital/University/Other Street Address City/State Zip			
j. month year TO month year	Hospital/University/other Street Address City/State Zip			
k. month year TO month year	Hospital/University/Other Street Address City/State Zip			
l. month year TO month year	Hospital/University/Other Street Address City/State Zip			

FORM 1

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, G.S. ADEBISI ADEGBILE, M.D. a licensed and practicing physician in the state of
Name of Recommending Physician

OHIO affirm that KATHLEEN GLOVER, M.D., has been known
Name of Applicant

to me personally and professionally for 3 years and that ~~he~~/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of ~~his~~/her application for full licensure:

I rate ~~his~~/her medical knowledge and technique as: Very adequate
~~his~~/her command of the English language is: Very good
I rate ~~his~~/her ability to work well with peers and medical staff as: Outstanding
~~his~~/her relationship with patients is: Excellent, gentle
Additional comments: _____

I hereby recommend ~~him~~/her for full licensure to practice medicine~~/osteopathic~~ medicine in Ohio.

[signature] MD
Signature of Recommending Physician

FREE PIKE MEDICAL CENTER, INC.
4001 FREE PIKE
DAYTON, OHIO 45416
Address of Recommending Physician
(Include City, State, Zip)

(SEAL)

G.S. ADEBISI ADEGBILE, M.D.
Name of Recommending Physician
(Please print or type)

513 - 274-0722
Telephone Number
(Include Area Code)

OHIO 034541
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 19th day of January, 1990.

Rhonda G. Wynn
Notary Public

April 28, 1990
Date Commission Expires

Kathleen Glover
Signature of Applicant

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

STATE MEDICAL BOARD OF OHIO
90 JAN 23 PM 12:15

Date Photo Taken

Dr Robinson -

FORM 1

AMG

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, Cheryl Jean Robinson M.D., a licensed and practicing physician in the state of
Name of Recommending Physician

Ohio affirm that KATHLEEN GLOVER, has been known
Name of Applicant

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

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

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

Cheryl J Robinson MD
Signature of Recommending Physician

Cheryl J. Robinson M.D.
Name of Recommending Physician
(Please print or type)

4001 Free Pike
Dayton OH 45416
Address of Recommending Physician
(Include City, State, Zip)

513 - 274 - 0722
Telephone Number
(Include Area Code)

Ohio 49949
State of Licensure and License Number
of Recommending Physician

(SEAL)

Subscribed and sworn to this 1st day of August, 1989.

Rhonda G. Wynn
Notary Public

April 1990
Date Commission Expires

PHOTO

Kathleen Glover
Signature of Applicant

April 1989
Date Photo Taken

AUG - 3 1989

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

Dr ADEGBILE

FORM 1

AMG

JUL 27 1989

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, G. S. ADEBISI ADEGBILE, M.D. licensed and practicing physician in the state of
Name of Recommending Physician

OHIO affirm that KATHLEEN GLOVER, has been known
Name of Applicant

to me personally and professionally for 4 years and that ~~he~~/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of ~~his~~/her application for full licensure:

I rate ~~his~~/her medical knowledge and technique as: AMPLY ADEQUATE
~~His~~/her command of the English language is: Excellent
I rate ~~his~~/her ability to work well with peers and medical staff as: Excellent
~~His~~/her relationship with patients is: Professional, genuine
Additional comments: Kathleen is a very caring, trustworthy

I hereby recommend ~~him~~/her for full licensure to practice medicine/~~osteopathic medicine~~ in Ohio.

Signature of Recommending Physician

4001 FREE PIKE
DAYTON, OHIO 45416
Address of Recommending Physician
(Include City, State, Zip)

(SEAL)

G. S. ADEBISI ADEGBILE, M.D.
Name of Recommending Physician
(Please print or type)

(513) 274-0722
Telephone Number
(Include Area Code)

OHIO - 034541
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this _____ day of _____, 19_____.

Notary Public

Date Commission Expires

Signature of Applicant

April, 1989
Date Photo Taken

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

FORM 2

STATE MEDICAL BOARD
90 JAN 18 PM 12: 47

CERTIFICATE OF POST-GRADUATE TRAINING

MAIL TO HOSPITAL OR INSTITUTION OF POSTGRADUATE TRAINING IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice medicine in the State of Ohio. The State Medical Board of Ohio requires that my postgraduate training be certified. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

This certifies that KATHLEEN GLOVER (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[X] intern (July 1, 1988 to June 30, 1989)
[ ] resident in Internal Medicine (Department)
[ ] clinical fellow

at Wright State Univ. Affiliated Hospitals (Name of Hospital), P.O. Box 927 Dayton, OH 45401-0927 (Complete Address of Hospital)

from July 1, 1988 beginning (month/day/year) to June 30, 1989 ending (month/day/year). It is further certified that the above name

[ ] was awarded a certificate on _____ (month/day/year)
[X] was not

and that the training

[X] ~~was~~ is accredited by ACGME/AOA.
[ ] was not

**Dr. Glover finished her PGY-1 year with our program as June 30, 1989. She has taken a one year leave of absence and will begin our program again as of July 1, 1990.

H. Verdain Barnes MD
Signature of Medical Director or Program Director
(Original signatures only, name stamps will not be accepted)

(SEAL OF HOSPITAL)

H. Verdain Barnes, M.D.
Name (Please print or type)

January 9, 1990
Date

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

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

The hospital has no seal. Sworn to and subscribed this 9th day January, 1990.

Kathleen E. Seibert
Notary Public

KATHLEEN E. SEIBERT, Notary Public
In and for the State of Ohio
My Commission Expires Sept. 30, 1991

THIS FORM SHALL NOT BE COMPLETED MORE THAN 30 DAYS PRIOR TO COMPLETION OF TRAINING

AD

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

MAIL TO HOSPITAL OR INSTITUTION OF POSTGRADUATE TRAINING IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice medicine in the State of Ohio. The State Medical Board of Ohio requires that my postgraduate training be certified. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

This certifies that KATHLEEN GLOVER (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[X] intern
[ ] resident in Internal Medicine (Department)
[ ] clinical fellow

at Wright State Univ. Affiliated Hospitals (Name of Hospital), Dept. of Medicine P.O. Box 927 Dayton, OH 45501-0927 (Complete Address of Hospital)

from July 1, 1988 (beginning (month/day/year)) to June 30, 1989 (ending (month/day/year)). It is further certified that the above name

[ ] was awarded a certificate on _____ (month/day/year)
[X] was not **

and that the training

[X] was accredited by ACGME/AOA.
[ ] was not

Signature of Medical Director or Program Director
(Original signatures only, name stamps will not be accepted)

(SEAL OF HOSPITAL)

H. Verdain Barnes, M.D.
Name (Please print or type)

July 12, 1989
Date

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

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

**Dr. Glover successfully completed her first year of training. For the academic year 1989-1990 she has taken a personal leave of absence. She will be rejoining us again July 1, 1990.

The hospital has no seal. Subscribed and sworn to this 12th day of July, 1989.

Kathleen E. Seibert
Notary Public

KATHLEEN E. SEIBERT, Notary Public
In and for the State of Ohio
My Commission Expires Sept. 30, 1991

ADDITIONAL INFORMATION

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO FURNISH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON AND DISPOSITION OF THE MATTER. ALL AFFIRMATIVE ANSWERS MUST BE THOROUGHLY EXPLAINED ON A SEPARATE SHEET OF PAPER.

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	[ ]	[XX]
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges for other than reasons of failure to maintain records on a timely basis or failure to attend staff or section meetings?	[ ]	[XX]
3.	Have you ever resigned, withdrawn, or terminated, or have you ever been requested to resign, withdraw, or otherwise terminate your position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	[ ]	[XX]
4.	Have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from a medical school, clinical clerkship, externship, preceptorship, or postdoctoral training program?	[ ]	[XX]
5.	Have you ever transferred from one postdoctoral training program to another?	[ ]	[XX]
6.	Have you ever, for any reason, lost Specialty Board Certification in the U.S. or elsewhere?	[ ]	[XX]
7.	Has any board, bureau, department, agency, or other body limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand against you?	[ ]	[XX]
8.	Have you ever voluntarily surrendered any professional license, certificate, or registration issued to you by a board, bureau, department, agency, or other body?	[ ]	[XX]
9.	Have you ever been requested to appear before any board, bureau, department, agency, or other body concerning allegations against you?	[ ]	[XX]
10.	Have you ever entered into an agreement of any kind with respect to a professional license, whether oral or written, in lieu of formal disciplinary action, with any board, bureau, department, agency or other body?	[ ]	[XX]
11.	Have you ever been notified of any charges or complaints filed against you with any board, bureau, deparment, agency, or other body with respect to a professional license?	[ ]	[XX]
12.	Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or other drugs affecting the central nervous system, or any drugs which may cause physical or psychological dependence?	[ ]	[XX]

13.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[XX]
14.	Have you ever been treated but not hospitalized, for emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[XX]
15.	Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, been requested to appear before or fined by the responsible agency?	[ ]	[XX]
16.	Have you ever been convicted or been found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	[XX]	[ ]
17.	Have you ever forfeited collateral, bail or bond for breach or violation of any law, police regulation, or ordinance other than for minor traffic violation, been summoned into court as a defendant, or had any lawsuit (other than malpractice suit) filed against you?	[ ]	[XX]
18.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf or paid such a claim yourself?	[ ]	[XX]
19.	Have you ever been denied, or relinquished, participation in any third party reimbursement program, whether governmental or private, or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	[ ]	[XX]
20.	Have you ever been denied licensure, application for licensure, or privilege of taking examination, or withdrawn any application, in any state, territory, province, or country for any reasons?	[ ]	[XX]

AFFIDAVIT AND RELEASE

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below must be completed by ALL applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being returned to you.

ss STATE OF OHIO

COUNTY OF CUYAHOGA

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

I acknowledge that I have read the general information and instructions for all applicants and the Routes to Licensure and I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that failure to complete this application as requested by the Board within six months can be considered as abandonment of any request for licensure and that any fee I submitted is not refundable or transferable.

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

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

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

Kathleen Glover
Signature of Applicant

Subscribed and sworn to before me this 22nd day of JANUARY 1990.

Karen M. Pippens
Notary Public Signature KAREN M. PIPPENS

(NOTARY SEAL)

2-19-91
Date Commission Expires

STATE MEDICAL BOARD OF OHIO
90 JAN 22 PM 4:31

033512

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO 75967

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

Ray L. Bumgarner

Entrance Examiner

Henry S. Cranfield M.D.

Secretary

2/12/90

Date Issued

FOR BOARD USE ONLY

NAME: GLOVER, Kathleen

CERTIFICATE #: 59888 DATE ISSUED 5-21-90

FILED 1/19, 19 90

FEE

DETERMINATION: 5/90 BM

BOARD ACTION:

BASIS OF LICENSURE:

Miami Valley

RECEIVED

FEB 07 1990

DEPARTMENT OF MEDICINE

STATE OF OHIO
THE STATE MEDICAL BOARD
17th Floor
77 South High Street
Columbus, Ohio 43266-0315

DATE January 31, 1990

Dear Doctor:

Dr. GLOVER, Kathleen who is/was Intern 7/88-7/89 is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 4 yrs.

(2) What was/is your supervisory capacity? Prof & Chair

(3) At what hospital? WSU SOM + WSU Intern Med Res.

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

(5) In your opinion, is this doctor a person of good moral and ethical character? Yes

(6) Does this doctor work well with peers and medical staff? Yes

(7) Does he/she relate well to patients? Yes

(8) How is his/her command of the English language? (if applicable) N/A

(9) Would you recommend this doctor for licensure? Yes

Additional comments, please: (if needed, an extra sheet of paper may be used)

Please return this form to the Ohio State Medical Board at the above address,
Sincerely,

Dawn Cales
Dawn Cales
Licensure Assistant

Signature of Doctor, please type or print name legibly beneath

H. Verdain Barnes, M.D.

Professor & Chair
Position

DATE: February 27, 1990

Telephone No. 513-220-2010 (Include Area Code)

90 MAR -2 PM 12:01
STATE MEDICAL BOARD
OHIO

Cy & Julie
3/9/90

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

JUL 19 1989

Kathleen Glover, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest L. THOMPSON BOWLES, M.D., PH.D.
Chairman of the Board

SEAL ROBERT L. VOLLE, PH.D.
President of the Board

Philadelphia, Pa.
07/01/89

Certificate # 355808

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from WRIGHT STATE U SCH OF MED in JUNE 1988 and whose birth date is 07/05/1949. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/86		
Anatomy	425	76
Physiology	440	77
Biochemistry	305	68
Pathology	500	81
Microbiology	310	68
Pharmacology	375	73
Behavioral Sciences	485	80
TOTAL TEST (Minimum Passing Score 380/75	380	75
PART II passed 09/87		
Internal Medicine	405	77
Surgery	435	79
Obstetrics and Gynecology	575	86
Public Health and Preventive Medicine	420	78
Pediatrics	470	81
Psychiatry	375	76
TOTAL TEST (Minimum Passing Score 290/75	430	79
PART III passed 03/89		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75	450	80
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		78

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Melanie Valente
Secretary for Certification

SEAL

07/14/89
Date

Wright State University

By authority of the Board of Trustees and on recommendation

of the Faculty hereby confers upon

Kathleen Glover

the Degree of

Doctor of Medicine

With all the honors, rights and privileges belonging thereto.

In Testimony Whereof this Diploma is granted, bearing the Seal of the University

and the signatures of its Duly Authorized Officers at Dayton, Ohio,

this eleventh day of June, nineteen hundred and eighty-eight.

Chair, Board of Trustees

President of the University

AD DOCENDUM INVESTIGANDUM SERVIENDUM

WRIGHT STATE UNIVERSITY 1967

John O. Kuckuck, M.D.

Dean

4-22-89

Medical Board -
State of Ohio

S.F.
SENT
5/3/89

Dear Sirs / Mdms;

Please send me the forms required for licensure in the State of Ohio.

I Am a ~~Not~~ National Board Medical Examination. diplomate who is seeking licensure by endorsement of the NBME certification.

Thank you.

KATHLEEN GLOVER
626 OMAR CIRCLE
YELLOW SPRINGS, OHIO
45387

GLOVER, KATHLEEN

Kathleen Glover
626 Omar Circle
Yellow Springs, OH 45387

1/21/90

#16

In 1985, while a student at Wright State Medical School, I wrote a check which bounced. I paid the check, but was fined for disorderly conduct. This occured in Fairborn , Ohio 11/85. The check was to Kroger Food Store. The police have this recorded as Cr-9175-85. (The Fairborn Police Department) I have sought counsel from an attorney to have this incident deleted from my records, since this has not happened (and will not happen) again.

Kathleen Glover

Kathleen Glover

D on Resume

7/89 to 6/90
On leave from residency program--Wright State University Internal Medicine
This leave was taken for personal reasons, to spend the year with my children
They are seniors in high school, and this is their last year to be at home.
I am returning to the residency program in July of 1990. During the year 7/89
to 6/90, I worked with Dr. Morris Brown, as indicated of the resume under
letter C.

Kathleen Glover
296-48-4786

1/21/90

#16

In 1985, while a student at Wright State Medical School, I wrote a check which bounced. I paid the check, but was fined for disorderly conduct. This occured in Fairborn , Ohio 11/85. The check was to Kroger Food Store. The police have this recorded as Cr-9175-85. (The Fairborn Police Department) I have sought counsel from an attorney to have this incident deleted from my records, since this has not happened (and will not happen) again.

Kathleen Glover

Kathleen Glover

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Kathleen Glover 9/25/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-9888	$160.00	07/01/92

KATHLEEN GLOVER, M.D.
626 OMAR CIRCLE
YELLOW SPRINGS OH 45387

2-6
4-13-33
10-21-92
160.00 pd 1550

:96969696 21:

0935059888 00000160000

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

18 GENERAL PREVENTIVE MEDICINE
17 GENERAL PRACTICE

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NO CONTEST TO :

YES NO
☐ ☑ A.) A felony or misdemeanor.
☐ ☑ B.) A federal or state law regulating the possession, distribution or use of any drug?

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

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

YES NO
☐ ☑ 2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO
☐ ☑ 3.) Surrendered, or consented to limitation upon: a) A license to practice medicine, OR b) State or federal privileges to prescribe controlled substances?

YES NO
☐ ☑ 4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Kathleen Glover 4/4/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-9888	$250.00	05/01/94

KATHLEEN GLOVER,M.D.
PO BOX 144
626 OMAR CIRCLE
YELLOW SPRINGS OH 45387

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GPM GENERAL PREVENTIVE MEDICINE
GP GENERAL PRACTICE

☑ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 0935059888 :00000250000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

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

YES NO ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

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

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

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

YES NO ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

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

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

YES NO ☑ 8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

[redacted]
SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

001 13 0187 07 1594 935059888
TAX PATH T DATE AMOUNT BATCHDATE ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 3/13/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-9888	$250.00	05/01/96

KATHLEEN GLOVER,M.D.
PO BOX 144
~~626 OMAR CIRCLE~~
YELLOW SPRINGS OH 45387

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GPM GENERAL PREVENTIVE MEDICINE
GP GENERAL PRACTICE

PROCESSED 04/03/96 09:23:1
SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

PO Box 144
STREET
STREET
Yellow Springs OH 45387
CITY STATE ZIP CODE
Greene
COUNTY

:96969696 2: 935059888 00000 25000

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

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

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES NO

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

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

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

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES NO

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

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

8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement? YES NO

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

883 00082 040196 04439
TAX BATCH P DATE SEQ# MC#
250 00 031996
AMOUNT BOTCHDATE
935059888
ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Kathleen Glover 7/3/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-9888-G	$305.00	10/01/2000

KATHLEEN GLOVER,M.D.
PO BOX 144
YELLOW SPRINGS OH 45387

STATE MEDICAL BOARD
JUL - 5 2000

246-48-4786
#39-1-53
#118
$305 7.700

:96969696 2: 0935059888 :0000030500:

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

IM INTERNAL MEDICINE
GPM GENERAL PREVENTIVE MEDICINE
GP GENERAL PRACTICE

☑ SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

1750 RANDALL ROAD
STREET
STREET
YELLOW SPRINGS OH 45387
CITY STATE ZIP CODE
GREENE
COUNTY

MUST BE ENTERED AT EACH RENEWAL

1750 RANDALL ROAD
Street
Street
YELLOW SPRINGS OH 45387
City State Zip Code
GREENE
County

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

YES ☐ NO ☒ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a misdemeanor or felony?

YES ☐ NO ☒ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question if** you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☒ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☐ NO ☒ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?

YES ☐ NO ☒ 5.) Have you surrendered, or consented to limitation of a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☐ NO ☒ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

REQUIRED:
SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

13122

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2000 - 2002 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** *AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.*

X Kathleen Glover 8/17/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-05-9888-G	$305.00	10/01/02	01/01/03

KATHLEEN GLOVER,M.D.
PO BOX 144
YELLOW SPRINGS OH 45387-0144

0935059888 30500

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

IM INTERNAL MEDICINE
GPM GENERAL PREVENTIVE MEDICINE
GP GENERAL PRACTICE

OHIO STATE MEDICAL BOARD
SEP 13 2002

☑ SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

PO BOX 144
STREET
STREET
YELLOW SPRINGS OH 45387
CITY STATE ZIP CODE
GREENE
COUNTY

APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

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

2.) *Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?* ***You may answer "NO" to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.*** YES ☐ NO ☒

3.) *Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?* YES ☐ NO ☒

4.) *Has any board, bureau, department, agency, or other body, including those in Ohio;* ***other than this board,*** *filed any charges, allegations or complaints against you?* YES ☐ NO ☒

5.) *Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.* YES ☐ NO ☒

6.) *Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons* ***other than failure to maintain records on a timely basis or to attend staff meetings?*** YES ☐ NO ☒

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

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

3049 NORTH HIGH STREET
Street
Street
Columbus OH 43202
City State Zip Code
Franklin
County

REQUIRED: [redacted]
SOCIAL SECURITY NUMBER

091802002 711700
1 0049 025
059088
1 SE 000030500

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION IN COMPLIANCE WITH O.R.C. 4731.281 AND O.A.C. 4731-10, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Kathleen Glover 7/10/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 059888	305.00	10/1/2004	1/1/2005

Dr. KATHLEEN GLOVER
PO BOX 144
YELLOW SPRINGS OH 453870144

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

IM
GPM
GP

☑ SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

1750 RANDALL ROAD
STREET
P.O. BOX 144
STREET
YELLOW SPRINGS OH 45387
CITY STATE ZIP CODE
GREENE
COUNTY

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

0003657332 30500 35ZZ 059888

APPLICATION FOR LICENSURE / RENEWAL IN OHIO :

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

YES ☐ NO ☑ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.**

YES ☐ NO ☑ 3.) Have any malpractice awards or settlements been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☐ NO ☑ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?

YES ☐ NO ☑ 5.) Have you surrendered, or consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☐ NO ☑ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
☐ Check this Box if you have NO principal Practice address.

2040 NORTH HIGH STREET
Street
Street
COLUMBUS OH 43202
City State Zip Code
FRANKLIN
County

[redacted]
SOCIAL SECURITY NUMBER

08202004 711700
1 0069035
1 SE 000030500

Date Posted: 12/28/2006 4:16:29 PM

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

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

Address Information

BUSINESS ADDRESS	4818 Indianola Columbus, OH 43214 Franklin County United States of America
CREDENTIAL MAIL ADDRESS	2530 Sutton Road YELLOW SPRINGS, OH 45387 Greene County United States of America 937 372 5353
MAIN	2530 Sutton Road Yellow Springs, OH 45387 Greene County United States of America 937 372 5353

License Information

License Number	35.059888
License Name	KATHLEEN GLOVER
Email Address	

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . INTERNAL MEDICINE

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

. . . . . GYNECOLOGY

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . YES

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or

document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

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

Date Posted: 8/20/2008 2:43:41 PM

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

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

License Information

License Number	35.059888
License Name	KATHLEEN GLOVER
Email Address	kgheart@aol.com

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

against you?

. . . . . NO

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

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Date Posted: 8/17/2010 8:24:03 PM

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

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

Address Information

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	Total Fees **$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . INTERNAL MEDICINE

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

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. . . . . NO

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

Date Posted: 10/20/2012 12:44:15 PM

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

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

License Information

License Number	35.059888
License Name	KATHLEEN GLOVER

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . INTERNAL MEDICINE

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

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

. . . . . YES

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

. . . . . NO

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

. . . . . NO

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

occurring in any state other than Ohio?

. . . . . NO

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

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

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. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 30-34

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

. 0

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

. 1-4

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

. 0

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

. 0

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

. 0

Clinical - Practice setting

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

. 30-34

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

. 0

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

. 0

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

. 25-29

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

. 5-9

Workforce Counties

1. Enter the first zip code:

. 45505

2. Enter the first county:

. . . . . Greene

3. Enter the second zip code:

. 45384

4. Enter the second county:

. . . . . Greene

5. Enter the third zip code:

. 43078

6. Enter the third county:

. . . . . Champaign

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

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

. . . . . 38 S. Burnett Road, Springfield, Ohio 45505; 2200 N. Limestone Suite

102, Springfield, 45505; Upper Valley Pike at Creekwood, Springfield, 45505;
848 Scioto St, Suite 2B, Urbana 43078

Practice Arrangement (size)

1. Solo practitioner

. . . . . YES

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

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

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

Date Posted: 12/9/2014 6:42:00 AM

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

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License Information

License Number	35.059888
License Name	KATHLEEN GLOVER

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . INTERNAL MEDICINE

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

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

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . YES

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** haveyou been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 20-24

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

setting or for a medical purpose

. 0

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

. 0

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

. 0

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

. 0

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

. 0

Clinical - Practice setting

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

. 20-24

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

. 0

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

. 0

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

. 15-19

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

. 5-9

Workforce Counties

1. Enter the first zip code:

. 45505

2. Enter the first county:

. . . . . Clark

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

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

. . . . . 848 Scioto Suite 2B, Urbana, Ohio 43078; 38 South Burnett, Springfield, Ohio 45505; Clearing Paths 8517 North Dixie Drive, Dayton Ohio

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1760781363

DEA number

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

. . . . . BG2403917

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

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