State Medical Board of Ohio

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

MD

FOR BOARD USE ONLY
FEE: $75.00
BK: 35 PG: 23 LN: 15
DATE: 4/30/02 PMT: 1753

APPLICATION FOR TRAINING CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

PERSONAL INFORMATION

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

U.S. Social Security Number: [redacted]

Full Name (Use no initials):

Last (Surname)	First	Middle	Suffix (Jr., II)
Isley	Michelle	Marie	

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

Last (Surname)	First	Middle	Suffix (Jr., II)
None			

Physicians Address (Be sure to notify the Board of any change in address):

Number & Street			
1000 14th St SW			
City	**State**	**Zip Code**	**Country**
Willmar	MN	56201	USA

TRAINING PROGRAM INFORMATION

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

Hospital & Department: The Ohio State University
Number & Street: Dept. of Ob/Gyn N-500
1654 Upham Drive, Means Hall
City: Columbus, OH 43210
Zip Code:

Dates of Training: Beginning Date: Mo/Day/Yr 7/1/02 Ending Date: Mo/Day/Yr 6/30/03

J-1 and H-1B VISA

To be completed by International medical school graduates only:

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

OVER ⇨

8.

MEDICAL OR OSTEOPATHIC EDUCATION

Medical or Osteopathic School of Graduation:

School Name: University of Minnesota Medical School
Street Address: 420 Delaware Street S.E.
City: Minneapolis | State: MN | Country: USA

Dates Attended: From: Mo/Yr 08/98 To: Mo/Yr 05/02

Degree Received: Doctor of Medicine | Date Received: Mo//Day/Yr 05/11/02

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

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

Dates Attended: From: Mo/Yr / To: Mo/Yr /

Reason degree not received at this school:

FIFTH PATHWAY PROGRAM

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

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

Dates Attended: From: Mo/Yr / To: Mo/Yr /

ECFMG CERTIFICATE NA

To be completed by International medical school graduates only:

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

Number:_____ Date Issued: Mo//Day/Yr / / Expires: Mo//Day/Yr / /

CONTINUED ⇨

9.

PHYSICAL DESCRIPTION

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

Birth Date: Mo/Day/Yr	Birth Place: City	State	Country
09/27/74	Ellendale	ND	USA

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

Date Photo Taken: 03/02 (mo/yr)

PHYSICAL DESCRIPTION:

Height 5'4"

Weight 150#

Hair Color Brown

Eye Color Brown

Identifying Marks _____

LICENSES IN THE UNITED STATES & CANADA

List ALL states/provinces, whether the license is current or not, in which you are or have been licensed, including temporary, educational permits, limited licenses, etc., to practice medicine and surgery or osteopathic medicine and surgery. Indicate license number, date of issuance and the type of license. If additional space is needed, attach an extra sheet. **(If none, enter "NONE")**

STATE/PROVINCE	ISSUE DATE	LICENSE #	TYPE OF LICENSE	LICENSE CURRENT
	MO/YR		*✓ONLY ONE*	*✓ONLY ONE*
None			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date: _____
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date: _____
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date: _____

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES

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

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

A

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

B

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

C

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

D

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

OVER ⇨

11.

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES
PAGE 2

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

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
ADDITIONAL INFORMATION

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

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

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☒
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☒
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☒
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	☐	☒
5.	Have you ever transferred from one graduate medical education program to another?	☐	☒
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☒
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☒
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☒
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☒

OVER ⇨

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☒
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☒
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
14.	Have you ever been denied, or have you ever surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☒
15.	Have you ever been convicted or found guilty of a violation of any law, regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☒
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☒
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☒
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☒
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☒
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☒

CONTINUED ⇨

14.

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

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

* *

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

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

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

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

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

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

b)	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	☐	☒

OVER ⇨

State Medical Board of Ohio

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

CERTIFICATION OF HOSPITAL

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by the Ohio training program in which I will be training. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

TO BE COMPLETED BY APPLICANT

Name of Applicant: Isley (Last) Michelle (First) Marie (Middle) _____ (Suffix (Jr., II))

TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: The Ohio State University Hospital

Training Program Address: Medical Staff - GME Office
Battelle Bldg. #13 - 1375 Perry St.
Columbus, OH 43210

Zip Code

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

Specialty Code (*see reverse side*): OBG

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

Dates of Training (***not to exceed one year***): Beginning Date: MO/DAY/YR 07/01/02 Ending Date: MO/DAY/YR 06/30/03

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

HOSPITAL SEAL

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

Signature of Medical Director or Program Director

ANDREW THOMAS

Name (please print)

4/23/02

Date

18.

SPECIALTY CODES

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

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

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

State Medical Board of Ohio

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ACKNOWLEDGMENT OF APPLICATION FOR TRAINING CERTIFICATE

May 22, 2002

MICHELLE MARIE ISLEY
C/O OSU HOSPS-CORP CRED OFC-A.SMITH
1375 PERRY STR 5TH FLR RM 526
COLUMBUS, OHIO 43210-0000

APPLICATION RECEIVED: 4/30/02

HOSPITAL: OHIO STATE UNIVERSITY - COL
Intern
OBSTETRICS & GYNECOLOGY

ACKNOWLEDGMENT LETTER EXPIRES: 10/29/02

Dear Doctor:

This is to notify you that your application for a training certificate was received by the Board on the above date and for the program indicated above.

Please be advised that you are hereby authorized to begin participation in the training program to which you have been appointed while your application is being processed. You are entitled to perform such acts as may be prescribed by or incidental to the internship, residency, or clinical fellowship program, but are not otherwise entitled to engage in the practice of medicine or surgery or osteopathic medicine and surgery in this state. You must limit your activities to the programs of the hospitals or facilities for which you have applied. You must train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program. **The authority granted by this letter will expire on the date indicated above.**

Applications are processed in the order received. An incomplete application or any unusual circumstances discovered during processing will result in deviation from this schedule. You will be notified if the application is incomplete or contains errors; or if there is difficulty in obtaining the independently requested recommendations.

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

Sincerely,

Penny E. Grubb
Chief, Licensure

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

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

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

	b) Are the limitations or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? if yes, please explain.	☐	☒

* *

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

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

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

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

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

The affidavit and release MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF: Minnesota

COUNTY OF: ~~Hennepin~~ Ramsey

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

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

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

I further understand that my application for a training certificate in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a training certificate and that any fee I submitted is neither refundable nor transferable.

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

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

I further understand that I must limit my activities under the certificate to the programs of the hospitals or facilities for which the training certificate is issued; and that I may train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program.

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

Michelle Marie Isley

Signature of Applicant

Subscribed and sworn to before me this 8 day of April 20 2002.

Signature of Notary Public

(NOTARY SEAL)

REX POYAOAN
Notary Public
Minnesota
My Commission Expires Jan. 31, 2005

01-31-2007

Date Commission Expires

17.

THE OHIO STATE UNIVERSITY
UNIVERSITY MEDICAL CENTER

University Hospitals
Medical Staff Affairs

Room 588, Battelle Bldg. 13
1375 Perry Street
Columbus, OH 43201

Phone: (614) 293-7444
FAX: (614) 293-7443

May 20, 2002
University of Minnesota
420 Delaware St. S.E.
Minneapolis, MN 55455

RE: Practitioner: Michelle Isley SS: [redacted]
Degree: M.D. From: 2002

To Whom It May Concern:

The above-named practitioner has applied for membership and/or privileges at The Ohio State University Medical Center and has indicated on his/her application that he/she is a graduate of your program.

In order to process his/her application, we must verify the applicant's date of graduation and the degree confirmed. We would appreciate your verifying this information below. An information release form and self-addressed envelope are enclosed for your convenience in replying.

Sincerely,

Medical Staff Affairs

****

Is the above information correct? [X] Yes [ ] No

During the time noted in Section 1, has this practitioner ever been subject to any disciplinary action, such as admonition, reprimand, suspension or termination? [ ] Yes [X] No
Note: If the answer is yes, please give details below or on a separate sheet.

Did the practitioner satisfactorily complete the program? [X] Yes [ ] No
If no, please explain.
COMMENTS:

June 18, 2002
Date

Helene M. Horwitz
Signature

Helene M. Horwitz, Ph.D.
Print Name

Associate Dean Student Affairs
Title

Rev. 8/00

4-25-02 - page sent to OSU Med. Staff Office as.

State Medical Board of Ohio

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

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1B - CERTIFICATION OF MEDICAL EDUCATION GRADUATES OF SCHOOLS LOCATED IN THE UNITED STATES OR CANADA ONLY

Instructions to Hospital Training Program: If you receive verification of graduation directly from the applicant's medical/osteopathic school, please complete the form below and return directly to the State Medical Board of Ohio at the above address. You must also submit a copy of the document(s) you obtained to verify the applicant's graduation from medical/osteopathic school.

TO BE COMPLETED BY APPLICANT

Name: Isley (Last) Michelle (First) Marie (Middle) _____ (Suffix (Jr., II))

Medical/Osteopathic School of Graduation: University of Minnesota Medical School

Location: Minneapolis (City) MN (State) USA (Country)

TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: _____

Training Program Address: _____ (Street Address)

THE OHIO STATE UNIVERSITY HOSPITALS
MEDICAL STAFF CREDENTIALS OFFICE
Battelle Bldg. #13 - 1375 Perry Street
Columbus, OH 43210

_____ (Department)

_____ (City) _____ (State) _____ (Zip Code)

I hereby **CERTIFY** that I received verification directly from the above-named applicant's medical/osteopathic school of graduation. I have attached a copy of the verified document(s).

HOSPITAL SEAL

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

Anne M. Smith
Signature of Medical Director or Program Director

Anne M. Smith
Name (please print)

9-23-02
Date

21.

State Medical Board of Ohio

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1A - VERIFICATION OF MEDICAL EDUCATION
TO BE COMPLETED BY LCME OR AOA ACCREDITED SCHOOLS ONLY

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

TO BE COMPLETED BY APPLICANT

Name: _____
Last First Middle Suffix (Jr., II)

Name of Medical/Osteopathic School: N/A

Location: _____
City State Country

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

_____ _____
Signature of Applicant Date

TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

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

attended medical/osteopathic school from _____ to _____ N/A
mo/day/yr mo/day/yr

This individual *(check one)*:

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

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

AFFIX INSTITUTIONAL SEAL

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

_____
Signature

_____
Name (please print)

_____
Title

_____
Date

THE OHIO STATE UNIVERSITY
UNIVERSITY MEDICAL CENTER

University Hospitals
Medical Staff Affairs

Room 588, Battelle Bldg. 13
1375 Perry Street
Columbus, OH 43201

Phone: (614) 293-7444
FAX: (614) 293-7443

57.6487

RECEIVED
JUN 26 2002
OFFICE OF THE MEDICAL DIRECTOR

REC'D JUN 18 2002

May 20, 2002
University of Minnesota
420 Delaware St. S.E.
Minneapolis, MN 55455

RE: Practitioner: Michelle Isley SS: [redacted]
Degree: M.D. From: 2002

To Whom It May Concern:

The above-named practitioner has applied for membership and/or privileges at The Ohio State University Medical Center and has indicated on his/her application that he/she is a graduate of your program.

In order to process his/her application, we must verify the applicant's date of graduation and the degree confirmed. We would appreciate your verifying this information below. An information release form and self-addressed envelope are enclosed for your convenience in replying.

Sincerely,

Medical Staff Affairs

****

Is the above information correct? [X] Yes [ ] No

During the time noted in Section 1, has this practitioner ever been subject to any disciplinary action, such as admonition, reprimand, suspension or termination? [ ] Yes [X] No
Note: If the answer is yes, please give details below or on a separate sheet.

Did the practitioner satisfactorily complete the program? [X] Yes [ ] No
If no, please explain.
COMMENTS:

June 18, 2002
Date

Helene M. Horwitz
Signature

Helene M. Horwitz, Ph.D.
Print Name

Associate Dean Student Affairs
Title

Rev. 8/00

STATE MEDICAL BOARD OF OHIO

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

MICHELLE MARIE ISLEY,
C/O OSU HOSPS-CORP CRED OFC-A.SMITH
1375 PERRY STR 5TH FLR RM 526
COLUMBUS OH 43210

09/27/2002

NUMBER : 57-00-6487
HOSPITAL : OHIO STATE UNIVERSITY - COL
INTERN OBSTETRICS & GYNECOLOGY

DATES : 07/01/2002 - 06/30/2003

Dear Doctor :

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

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

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

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

Sincerely,

Penny E. Grubb
Chief, Licensure

B1471

State Medical Board of Ohio

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

#335
#0749
7/8/04

FOR BOARD USE ONLY
BK:_____ PG:_____ LN:_____
DATE:_____ FEE: **$335.00** PMT:_____

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

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

IDENTIFICATION

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

U.S. Social Security Number	[redacted]			
Full Name (Use no initials)	Last (Surname): Isley	First: Michelle	Middle: marie	Suffix (Jr., II):
Name (As you prefer it inscribed on your Ohio license)	Last (Surname): Isley	First: Michelle	Middle: M.	Suffix (Jr., II):
Maiden Name or Other Names Used (If none, enter "NONE")	Last (Surname):	First:	Middle:	Suffix (Jr., II):
Current Home Address IMPORTANT Notify the Board office immediately in writing of any change in address	Number and Street: 2105 Harwitch Rd.		Apt.:	
	City: Columbus	State: OH	Zip Code: 43221	Country: USA
Telephone Number	Business: Area Code & Number (614) 293-8512		Home: Area Code & Number (614) 486-5034	
Birth Date	month/day/year: 09/27/1974	**Birth Place** City: Ellendale	State: ND	Country: USA
Physical Description	Height: 5'4"	Weight: 150	Hair Color: Brown	Eye Color: Brown
	Identifying marks: N/A			
Gender	☐ Male	☑ Female	For statistics only (optional)	

OHIO STATE MEDICAL BOARD
JUL 06 2004

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

The Ohio State University Medical Center — Name of Hospital/Training Program
Location: Columbus, OH
Starting Date: 06/2002 (month/day/year)

OVER ⇨

WRITTEN EXAMINATION

Indicate which licensing examination(s) you have passed:

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

LICENSES IN THE UNITED STATES AND CANADA

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

STATE/PROVINCE	ISSUE DATE (MO/YR)	LICENSE NO.	LICENSE CURRENT YES	LICENSE CURRENT NO	EXPIRE(S)
Ohio	09/2002	57.006487	☒	☐	06/30/2004 Active in Renewal
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

SPECIALTY BOARDS

NAME OF SPECIALTY BOARD (If none, enter "N/A")	YEAR CERTIFIED	COUNTRY
N/A		OHIO STATE MEDICAL BOARD
		JUL 06 2004

CONTINUED ⇨

FEDERATION CREDENTIALS VERIFICATION SERVICE

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

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

If yes, date forwarded:_____ FCVS Packet ID Number (if known): 41444

ECFMG CERTIFICATE
(International Medical School Graduates only)

ECFMG Number		Date Issued		Expiration Date	

TEST OF SPOKEN ENGLISH
(International Medical School Graduates only)

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

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

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

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

RESUME OF ACTIVITIES - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order beginning with medical school graduation to the PRESENT time, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", as well as your permanent address.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets.

From / To	Hospital, University or Other / Complete Street Address / City / State/Country / Zip Code	Position & Department	% Clinical / % Admin.
From Month/Year 6/02 To Month/Year Present	The Ohio State University Medical Center 410 W. 10th Columbus OH/USA 43210	Resident OB/Gyn	100 %
From Month/Year / To Month/Year /			
From Month/Year / To Month/Year /			
From Month/Year / To Month/Year /			
From Month/Year / To Month/Year /			
From Month/Year / To Month/Year /			

OHIO STATE MEDICAL BOARD
OVER ⇨
JUL 06 2004

ADDITIONAL INFORMATION
MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

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

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☒
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☒
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☒
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	☐	☒
5.	Have you ever transferred from one graduate medical education program to another?	☐	☒
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☒
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☒
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☒
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☒

OVER ⇨

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☒
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☒
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☒
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☒
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☒
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☒
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☒
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☒
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☒

CONTINUED ⇨

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

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

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

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

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

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

OVER ⇨

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

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

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

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

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

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

State Medical Board of Ohio

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

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **This form must be notarized by the recommending physician.** ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

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

I, Cherie Richey (recommending physician, print name), a licensed and practicing physician in the state of Ohio (state of residence)

affirm that Michelle Isley (applicant, print name) has been known to me personally for 3 years

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

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

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio. 614-

Address of Recommending Physician	Number & Street: 1813 Aschinger Blvd.	Telephone Number (include area code)	353-6697
	City: Col State: OH Zip Code: 43212		
Signature of Recommending Physician (name stamps not acceptable)	[signature]	State of Licensure & License Number	OHIO 35-08-3577-R

Signature of Applicant [signature]

Date Photo Taken: 04 / 04 (Mo/Yr)

Subscribed and sworn to before me this 21st day of June, 2004.

Notary Public Signature [signature]

Date Commission Expires: 3/28/09

SHARON WAGNER
Notary Public, State of Ohio
My Commission Expires 03-28-09

NOTARIAL SEAL STATE OF OHIO

NOTARY SEAL

OHIO STATE MEDICAL BOARD

JUL 0 6 2004

State Medical Board of Ohio

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

FORM 1 - CERTIFICATE OF RECOMMENDATION MEDICINE OR OSTEOPATHIC MEDICINE

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **This form must be notarized by the recommending physician.** ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

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

I, LINBEE V. SAYAT (recommending physician, print name), a licensed and practicing physician in the state of OHIO (state of residence),

affirm that MICHELLE ISLEY (applicant, print name) has been known to me personally for 2 years

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

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

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

Address of Recommending Physician	Number & Street: 5240 PARKCREST LN City: COLUMBUS State: OH Zip Code: 43220	Telephone Number (include area code)	(614)837-4502
Signature of Recommending Physician (name stamps not acceptable)		State of Licensure & License Number	35-08-1111-S

Signature of Applicant

Date Photo Taken: 04/04 (Mo/Yr)

Subscribed and sworn to before me this 21st day of June, 2004.

Notary Public Signature

Date Commission Expires: 3/28/09

SHARON WAGNER
Notary Public, State of Ohio
My Commission Expires 03-28-09

NOTARIAL SEAL STATE OF OHIO

NOTARY SEAL

OHIO STATE MEDICAL BOARD

JUL 06 2004

Ob Urology ER

MEDICINE OR OSTEOPATHIC MEDICINE
PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	Isley	Michelle	Marie	

High School or Equivalent

School Name: Willmar Senior High School

City: Willmar | State: MN, USA | Country: 56201

Dates Attended — From: MO/YR 9/90 To: MO/YR 6/93

Undergraduate College or Equivalent

School Name: Concordia College

City: Moorhead | State: MN | Country: USA

Dates Attended — From: MO/YR 9/93 To: MO/YR 5/97 | Degree Received: BA Biology

School Name:

City: | State: | Country:

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

Medical or Osteopathic School of Graduation

School Name: University of Minnesota Medical School

City: Minneapolis | State: MN | Country: USA

Dates Attended — From: MO/YR 9/98 To: MO/YR 5/02 | Degree Received: M.D.

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 105957 DATE ISSUED: JUL 27 2004

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

Entrance Examiner

Secretary

OHIO STATE MEDICAL BOARD

JUL 06 2004

AFFIDAVIT AND RELEASE OF APPLICANT
MEDICINE OR OSTEOPATHIC MEDICINE

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

ss STATE OF: Ohio

COUNTY OF: Franklin

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

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

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

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change occurs at any time prior to a license to practice medicine or osteopathic medicine being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a license to practice medicine or osteopathic medicine and that any fee I submitted is neither refundable nor transferable.

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

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

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

Michelle M Isley
Signature of Applicant

Subscribed and sworn to before me this 8th day of June 2004.

Sarah A. Bourne
Signature of Notary Public

(NOTARY SEAL) Sarah A. Bourne
Notary Public
In and for the State of Ohio
My Commission Expires
January 6, 2007

Date Commission Expires

OHIO STATE MEDICAL BOARD

JUL 0 6 2004

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

Physician Information Profile

This report is compiled exclusively for:

Name:	**Michelle Marie Isley**
SSN:	[redacted]
DOB:	**09/27/1974**
Packet ID:	**41444**
Recipient:	**State Medical Board of Ohio**

NOTICE:

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

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

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Michelle Marie Isley**	
Other Name Used:	**N/A**	
Gender:	**Female**	
Date of Birth:	**09/27/1974**	
Place of Birth:	**Ellendale, ND USA**	
SSN:	[redacted]	
Current Address:	**2105 Harwitch Road** **Columbus, OH 43221**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**614-404-8663**
	Fax:	**614-293-5877**
	Home:	**614-486-5034**
	Other:	**614-730-6961**
Physical Description:	Height:	**5' 04"**
	Weight:	**150 lbs**
	Eye Color:	**Brown**
	Hair Color:	**Brown**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

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

Institution:	**Concordia College, Moorhead, MN 56562**
Dates of Attendance:	**08/1993 - 05/1997**
Degree Issued/Conferred:	**Bachelor of Arts**

Medical Education:

Medical School:	**University of Minnesota - Duluth School Of Medicine** **Academic Affairs** **236 School of Medicine** **10 University Drive** **Duluth, MN 55812**
Dates of Attendance:	**09/02/1998 - 05/02/2000**
Date Degree Conferred/Issued:	**N/A**
Degree Conferred/Issued:	**Did not receive degree**
Unusual Circumstance:	**None**

Medical School:	**University of Minnesota Medical School - Minneapolis** **1420 Eckles Avenue** **130 Coffey Hall** **St Paul, MN 55108**
Dates of Attendance:	**06/05/2000 - 05/11/2002**
Date Degree Conferred/Issued:	**05/11/2002**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Post Graduate Medical Education:

Institution:	**Ohio State University Hospital** **Department of Obstetrics and Gynecology** **1654 Upham Drive** **507 Means Hall Fifth Floor** **Columbus, OH 43210-1228**
Post Graduate Year:	**1**
Program Type:	**Residency**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2002 - 06/30/2003**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**2**
Program Type:	**Residency**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2003 - 06/30/2004**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

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

Board Action:

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

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician 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.

Physician Identification:

Name:	Michelle Marie Isley
DOB:	09/27/1974
SSN:	[redacted]
Packet ID:	41444
Request ID:	13364980

OMISSIONS

Omission 1:

Section of Profile: **Medical Education**

Omission: U Minnesota Duluth did not provide an official medical school transcript.

Follow-Up: See Certified Medical School transcript provided by the University of Minnesota Medical School - Minneapolis.

DISCREPANCIES

There are none identified.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile: **Continuity of Education**

Issue: There is a gap of approximately 1 1/2 years between completion of premedical education at Concordia College (ends 05/00/1997) and entrance into medical school at U Minnesota Duluth (begins 09/02/1998).

Follow-Up: Provided as information only. No follow up performed.

End of report for Michelle Marie Isley

Packet Id: 41444 Request Id: 13364980 Report Created By: JAV

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name:	**Isley, Michelle Marie**
Date of Birth:	**09/27/1974**
Medical School:	**024030 - U Minnesota Minneapolis**
Year of Graduation:	**2002**
Social Security Number:	[redacted]
ECFMG Number:	**N/A**

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

OCT 0 6 2004

DALE L. AUSTIN
SENIOR VICE PRESIDENT
AND CHIEF OPERATING OFFICER

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

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

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

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

M Isley

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

Isley

Applicant's **Printed** Last Name

Michelle, M.

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

4-26-2004

Date of Signature (must correspond to date of notarization)

State of Ohio, County of Franklin,
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 26th day of April, 2004.

Notary Public signature: Susan K DuPont

My commission expires: 02-03-08

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

Federation Credentials Verification Service

REC'D OCT 8 1974

NORTH DAKOTA

CERTIFICATE OF LIVE BIRTH

STATE DEPARTMENT OF HEALTH

Birth Number 74-007469

133-

Local Registrar's File No. 6411

TYPE, OR PRINT IN PERMANENT INK SEE HANDBOOK FOR INSTRUCTIONS

CHILD

CHILD—NAME (FIRST / MIDDLE / LAST)	DATE OF BIRTH (MONTH, DAY, YEAR)	HOUR
1. MICHELLE MARIE ISLEY	2a. September 27, 1974	2b 8:35 P.M.

SEX	THIS BIRTH—SINGLE, TWIN, TRIPLET, ETC. (SPECIFY)	IF NOT SINGLE BIRTH—BORN FIRST, SECOND, THIRD, ETC. (SPECIFY)	COUNTY OF BIRTH
3. female	4a. single	4b. ----------	5a. Dickey

CITY OR TOWNSHIP OF BIRTH	INSIDE CITY LIMITS (SPECIFY YES OR NO)	HOSPITAL—NAME (IF NOT IN HOSPITAL, GIVE STREET AND NUMBER)
5b. Ellendale	5c. yes	5d. Dickey County Memorial Hospital

MOTHER

MOTHER—MAIDEN NAME (FIRST / MIDDLE / LAST)	AGE (AT TIME OF THIS BIRTH)	STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY)
6a. Donna Marie Johnson	6b. 31	6c. North Dakota

RESIDENCE—STATE	COUNTY	CITY OR LOCATION	INSIDE CITY LIMITS (SPECIFY YES OR NO)	STREET AND NUMBER
7a. No. Dak.	7b. LaMoure	7c. LaMoure	7d. yes	7e.

FATHER

FATHER—NAME (FIRST / MIDDLE / LAST)	AGE (AT TIME OF THIS BIRTH)	STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY)
8a. Jerry Frederick Isley	8b. 28	8c. North Dakota

INFORMANT	RELATION TO CHILD	MOTHER'S MAILING ADDRESS (STREET OR R.F.D. NO., CITY, STATE, ZIP)
9a. Donna Isley	9b. mother	Box 368, LaMoure, N. Dak. 58458

CERTIFIER

I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE.

10a. SIGNATURE	DATE SIGNED (MONTH, DAY, YEAR)	ATTENDANT—M.D., D.O., MIDWIFE, OTHER (SPECIFY)
Donald D Brown	10b. 9-30-74	10c. M.D.

CERTIFIER—NAME (TYPE OR PRINT)	MAILING ADDRESS (STREET OR R.F.D. NO., CITY, STATE, ZIP)
10d. R. D. Brown, M.D.	10e. Ellendale, N. Dak. 58436

REGISTRAR—SIGNATURE	DATE RECEIVED BY LOCAL REGISTRAR
11a. Marie Schlenker Deputy	11b. October 3, 1974

RECORDED

6 P. 21

INDEXED

SEAL

VERIFIED

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

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

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

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Minnesota - Duluth School Of Medicine

Complete Address:

Street Address: 1035 University Drive

City: Duluth **State:** MN **ZIP Code (Postal Code):** 55812

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: Minimum college graduation

Credential/degree presented by the applicant for admission to your medical school: BA/BS or Greater

Enrollment and Participation: Our records indicate that ISELY, MICHELLE MARIE
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 72 weeks of medical education on the following dates (mm/dd/yy):

From 9 / 2 / 1998 (Month / Date / Year) **To** 5 / 2 / 2000 (Month / Date / Year)

This individual (check one):

☐ was awarded the degree of _____ on ___/___/___ (Month / Date / Year)

☒ was NOT awarded a degree (please attach an explanation) First Two Years in Duluth. Transferred to U of Minnesota Minneapolis and graduated May 2002.

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

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

SEAL VERIFIED

Signature: James G Boulger

Title: Director Alumni Relations

Date of Signature: 8/2/04

Phone: (218) 726-7144 **Fax:** (____)

Email: jboulger@d.umn.edu

VERIFICATION OF MEDICAL EDUCATION

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

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

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

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

   Please Specify: _____

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

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

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

   Please specify reason: _____

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

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

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

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

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

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

PROVIDED BY APPLICANT

Applicant: Print your complete last name: Isley

17. U.S./Canadian Medical Education

Complete this page only if you have attended a medical school located in the U.S. or Canada.

List all the medical schools you attended in chronological order.

You may photocopy this page to report more than two (2) institutions if necessary.

If your medical school is outside of the United States, and/or you participated in a Fifth Pathway program, proceed to the next page.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8.5" x 11" sheet of paper. Your response may not exceed 100 words per question.

UNIVERSITY OF MINNESOTA-DULUTH
SCHOOL OF MEDICINE

Complete name of Institution #1 (Do not abbreviate)

DULUTH — City
MN — State

From: 09 (Month) 1998 (Year) To: 06 (Month) 2000 (Year)

Degree: ☒ None ☐ MD ☐ DO ☐ MD/PhD combined ☐ Did not graduate

Exact date of graduation: NA (Month) (Day) (Year)

Unusual Circumstances (circle yes or no):

Did you ever take a leave(s) of absence or break(s) from 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 ever filed against you?	Yes	(No)
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	Yes	(No)

Please explain any "Yes" responses from above:

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

REC'D JUN 08 2004

INSTRUCTIONS TO THE DEAN

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

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

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Minnesota Medical School - Minneapolis

Complete Address: MMC 293

Street Address: 420 Delaware Street Se

City: Minneapolis **State:** MN **ZIP Code (Postal Code):** 55455

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: 4 year degree

Credential/degree presented by the applicant for admission to your medical school: records do not indicate

Enrollment and Participation: Our records indicate that Isley, Michelle Marie
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 76* weeks of medical education on the following dates (mm/dd/yy):

From 06 / 05 / 2000 (Month / Date / Year) **To** 05 / 11 / 2002* (Month / Date / Year)

This individual (check one):

[X] was awarded the degree of Doctor of Medicine on 05 / 11 / 2002 (Month / Date / Year)

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

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

SEAL VERIFIED

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

Signature: Helene M. Horwitz

Title: Associate Dean of Student Affairs

Date of Signature: June 8, 2004

Phone: (612)624-8101 **Fax:** (612) 626-4200

Email:

*Dr. Isley transferred from the University of Minnesota Duluth School of Medicine on May 5, 2000 into the third year class at the University of Minnesota Minneapolis Medical School.

VERIFICATION OF MEDICAL EDUCATION

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

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

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

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

   Please Specify: _____

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

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

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

   Please specify reason: _____

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

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

   _____

   _____

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

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

   _____

   _____

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

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

   _____

   _____

PROVIDED BY APPLICANT

Applicant: Print your complete last name: Isley

17. U.S./Canadian Medical Education

Complete this page only if you have attended a medical school located in the U.S. or Canada.

List all the medical schools you attended in chronological order.

You may photocopy this page to report more than two (2) institutions if necessary.

If your medical school is outside of the United States, and/or you participated in a Fifth Pathway program, proceed to the next page.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8.5" x 11" sheet of paper. Your response may not exceed 100 words per question.

DOCUMENTATION: You must include a complete, legible photocopy of your medical school diploma.

If a break of six (6) months or more occurred between medical schools attended or between graduation from medical school and your first year PGT, please provide a written explanation outlining your activities during this "gap" period on the enclosed Gap Explanation Form.

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL

Complete name of Institution #1 (Do not abbreviate)

MINNEAPOLIS — City

MN — State

From: 09 (Month) 1998 (Year) To: 05 (Month) 2002 (Year) Degree: ☐ None ☒ MD ☐ DO ☐ MD/PhD combined ☐ Did not graduate

Exact date of graduation: 05 (Month) 11 (Day) 2002 (Year)

Unusual Circumstances (circle yes or no):

Did you ever take a leave(s) of absence or break(s) from 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 ever filed against you?	Yes	(No)
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	Yes	(No)

Please explain any "Yes" responses from above:

Complete name of Institution #2 (Do not abbreviate)

City — State

From: Month Year To: Month Year Degree: ☐ None ☐ MD ☐ DO ☐ MD/PhD combined ☐ Did not graduate

Exact date of graduation: Month Day Year

Unusual Circumstances (circle yes or no):

Did you ever take a leave(s) of absence or break(s) from 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 ever filed against you?	Yes	No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	Yes	No

Please explain any "Yes" responses from above:

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Medical School Education
Student Affairs

Box 293 Mayo
420 Delaware Street S.E.
Minneapolis, MN 55455
612-624-1188
Fax: 612-626-4200

November 1, 2001

Dear Program Director:

This is a letter of evaluation for **MICHELLE M. ISLEY**, a University of Minnesota medical student who is an outstanding candidate for your residency program.

Introduction:
Michelle graduated *magna cum laude* from Concordia College in Moorhead, Minnesota, with a Bachelor of Arts degree in Biology in 1997. She matriculated into the University of Minnesota-Duluth School of Medicine and transferred with her class into the University of Minnesota-Minneapolis Medical School on June 5, 2000. It is anticipated that Michelle will receive her M.D. degree in May 2002.

Preclinical Record:
Michelle has satisfactorily completed her basic science coursework. In her first two years, she received honor grades in Human Gross Anatomy and Psycho-Social-Spiritual Aspects of Life-Threatening Illness.

On Step 1 of the United States Medical Licensing Examination (USMLE), Michelle achieved a total score of 208.

Clinical Clerkship Record:
In the clinical portion of the curriculum she has performed with distinction. She has received an honors grade in Medicine I. She also achieved honors grades for the Rural Physician Associate Program (RPAP) in the Spring and Summer sessions respectively. Michelle was selected to participate in the University of Minnesota's Rural Physician Associate Program (RPAP) class of 2000-01. Up to 40 students in this program spend nine months of the third year of medical school under the supervision of a clinical primary care faculty member. Michelle spent RPAP in Aitkin, Minnesota (Population 1,698) at the Ripple River Medical Center, a family practice clinic. Her primary preceptor was Dr. Donald Hughes. During this time she received extensive hands-on clinical experience in a full spectrum of family practice medicine.

The following are representative narrative comments from evaluations:

OBSTETRICS/GYNECOLOGY (Summer 2000) Excellent
Michelle did an excellent on her first clinical rotation. She performed above expectations regarding the basics of doing a cogent and complete history and physical examination. She utilized clinical and academic sources very well. She performed in an outstanding manner in

following a patient's progress through labor, delivery, post-delivery, and post-surgical care. Her attitude with patients was also outstanding. She was empathetic, reassuring, caring, and supportive. She developed trust and rapport, and engendered confidence in her patient contacts. An evaluator said, "Michelle was an excellent student. She was enthusiastic and developed excellent rapport with patients and staff."

OTOLARYNGOLOGY (Summer 2000) Pass

Michelle was highly rated as an excellent student on a surgical subspecialty rotation. Not only were her basic skills excellent, but also her case presentations were complete, organized, and clear. She carried out assigned tasks in a responsible fashion, and showed initiative on the ward. Her fund of medical knowledge was excellent for her stage of training, and she approached problems with "interest and enthusiasm."

UROLOGY (Summer 2000) Pass

Michelle again performed in an excellent manner on this surgical subspecialty rotation. She continued to build on her well-established knowledge base and developed skills in synthesizing information to make comprehensive assessments of patients' problems. She delivered written and verbal case presentations, which were complete, organized, and clear. An evaluator said, "She has a strong desire to learn and finds resources when introduced to topics not yet encountered." She demonstrated compassion and caring to all of her patients and worked well with the entire health care team. She truly was a "pleasure to work with."

MEDICINE (Fall 2000) Outstanding

Michelle was an outstanding student on her first medicine rotation. Her work continued to be exceptional and become more refined. Her history and physical examination skills were outstanding, as was her ability to present the data in a concise and organized manner. Her problem-solving and reasoning skills were excellent. She demonstrated a real thirst for learning through daily independent study. She was considered to be "very diligent, thorough, and empathetic. Her medical knowledge is superb. She is energetic and develops good rapport with patients." An evaluator said, "I would enjoy having her as a colleague."

RURAL PHYSICIAN ASSOCIATE PROGRAM (RPAP) (Fall 2000 – Summer 2001)

Grades: Fall: Excellent (E) Spring: Outstanding (O) Summer: Honors (H)

Michelle excelled as an RPAP student. Over the period of nine months she had the opportunity to work with numerous community faculty, and received superlative evaluations from all of them. Her clinical skills became more refined, as did her diagnostic and therapeutic plans. Her written, verbal, and dictated reports were exceptional. She was very motivated and enthusiastic. She was able to see, evaluate, and care for patients from the very first of her rotation in a manner that was better than previous students at that location were. This is of particular significance, since Aitkin has hosted twenty-three previous students. She was well liked by patients and staff. She also enjoyed being involved in difficult and complicated medical problems. In working with a community surgeon, Michelle was rated as superb. She worked diligently to prepare for all of her cases, understood basic science principles, and followed the patient through surgery and post-operative care. She participated in a significant number of cases with a broad general surgical repertoire, regularly first-assisted, and participated extensively in pre and post-operative care. She accompanied the surgeon to the island of Hispaniola, where she, as part of a team, served the indigent population in a remote, mountainous village of Pignon, Haiti. Not only did

she work extremely hard in the medical-surgical capacity, she prepared a set of lectures and trained many local physicians, nurses, and other health care workers while there. The surgeon commented, "She did an outstanding job…I am very proud of her accomplishments; not only of the kind of doctor she is becoming, but the kind of young woman she represents for our medical school." Another family practice preceptor commented that she was "an outstanding student. She was always getting to work early and not afraid to get involved. She does a great job of gathering information and formulating treatment plans. She is motivated, enthusiastic, and one of the strongest students we've ever hosted."

NORMAL LABOR AND DELIVERY (Summer 2001) Honors

Michelle did an excellent job on this elective away rotation at the Ohio State University. Her basic skills and overall abilities and attitudes were very highly rated. One evaluator commented that Michelle had "an excellent attitude and rapport with patients, families and staff" She was also "inquisitive" and "very helpful to the team." Other comments included, "She has both the energy, interest and commitment to be a wonderful Ob/Gyn resident. She takes responsibility of following her patients and anticipating management plans. Her skills/procedures improved during the rotation, particularly vaginal delivery and episiotomy repairs. We would be happy to see her in our program."

Special Activities:

During college, Michelle was invited to participate as CREDO Honors Program graduate throughout her four-year program. She was also a Biology honors graduate, which culminated in a senior research project. Besides excelling academically, Michelle was also involved in Service Outreach Group and the CARES committee for chemical awareness. She participated in intramural volleyball and expressed her musical talent through participating in the band playing the flute for four years.

Michelle has demonstrated academic excellence by receiving several scholarships as a first and second year medical student, including: The UMD Scholarship Fund scholarship, the John George Ross Endowed Scholarship, and the Roger Dell Scholarship. In addition, she received the Microbiology Departmental Scholarship, which was awarded to the top microbiology student in the second year class at the University of Minnesota – Duluth School of Medicine. She was also invited to be a tutor for three class components including: nervous system, cardiovascular system, and fluid and electrolytes. This involved a commitment of approximately six hours per week. In addition, she was co-leader of a group, "Growing Healthy," in which medical students visited elementary and high schools in the Duluth area to give presentations to the classes about health-related topics.

Between college and medical school, Michelle spent one year in the Lutheran Volunteer Corps. During this time she was a residential aide at the Don Miller House, part of the AIDS Interfaith Residential Services. As part of her work, she assisted low-income residents who were suffering in the end stages of AIDS. She provided personal care, companionship, worked as a patient advocate, and performed housekeeping services for five residents. She describes this as "The most influential experience prior to medical school." She gained invaluable life experiences that were used to further develop her intellectual, emotional and physical strength, and her desire to succeed with her medical profession. This attitude of caring and service for the underserved populations was again manifested in her volunteer experience during RPAP called "Project Haiti." In March of 2001, she volunteered to join a medical-surgical team to travel to Haiti to

volunteer in the hospital, medical and surgical wards. She also provided lectures of health professional topics to local physicians, residents, nursing and operating room staff and students. In her rural community, she participated in the community choir, community education classes, and "Safety Town," a comprehensive safety awareness program for children. She has extensive experience as a tutor, counselor, office assistant, and laboratory assistant. She is a member of the Omicron Delta Kappa National Leadership Honor Society, as well as the American Medical Association (AMA), the American Medical Student Association, and the Minnesota Medial Association. Her desire to improve her medical knowledge and skills led her to participate in the Comprehensive Advanced Life Support (CALS) course offered in April 2001.

Personal Qualities:
Michelle is a hard working and enthusiastic student who goes above and beyond what is expected of her. She is independent, yet functions well as a member of a team. Her communication skills are outstanding. She has an empathetic and compassionate attitude, as well as being an outstanding listener. She is logical, yet sensitive, and pays attention to detail. Her positive attitude and willingness to give of herself to others is an inspiration. She has learned to balance the rigors of an academic and professional life with volunteering for those less fortunate and educationally challenged. Michelle is personable and has an excellent sense of humor. She pursues excellence in all that she does and is exceedingly determined. She is unafraid of assuming leadership roles and remains calm in stressful situations.

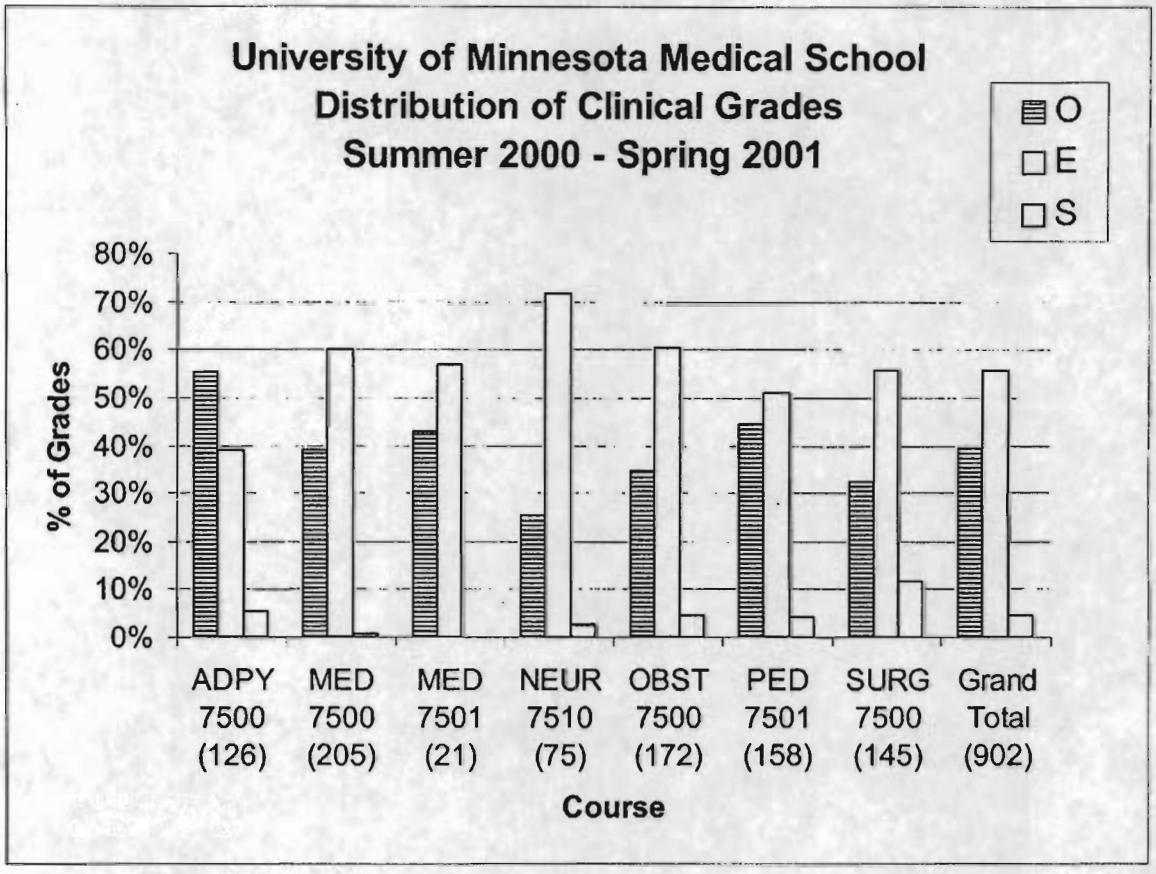
Summary:
After carefully considering several possible career paths, Michelle has chosen to seek a residency in obstetrics and gynecology. Not only does she enjoy all components of women's health care, she relates very well to female patients. She is enthusiastic about working with adolescents and geriatric patients, and providing both components of primary and specialty care for women. Her knowledge, abilities and procedural skills will allow her to develop into an outstanding obstetrician/gynecologist. She would eventually like to practice in an underserved area. This should be no surprise, as this has been part of her life throughout her adult years. Her goal is to also spend some time practicing international medicine in developing countries. As she gains experience and confidence, Michelle will emerge as an outstanding physician and teacher. She will develop into a superb resident and physician who will be an asset to her future training program.

In summary, **Michelle M. Isley** is an outstanding candidate for graduate medical education in your program.

Sincerely,

Walter M. Swentko

Walter M. Swentko, M.D., M.S.
Director
Rural Physician Associate Program


University of Minnesota Medical School
Distribution of Clinical Grades
Summer 2000 - Spring 2001
O
E
S
80%
70%
60%
50%
40%
30%
20%
10%
0%
% of Grades
ADPY 7500 (126)
MED 7500 (205)
MED 7501 (21)
NEUR 7510 (75)
OBST 7500 (172)
PED 7501 (158)
SURG 7500 (145)
Grand Total (902)
Course

University of Minnesota Official Transcript

University of Minnesota, Twin Cities

Name : Isley,Michelle Marie
Student ID: 1891871
Birthdate : 09-27

Print Date : 06-04-2004

MOST RECENT PROGRAMS
Institution : University of Minnesota, Twin Cities
Program : Medical School
Plan : Medicine M D Major
Degree Sought : Doctor of Medicine

- - - - - University of Minnesota Degrees and Certificates Awarded - - - - -

Degree : Doctor of Medicine
Confer Date : 05-11-2002
Acad Program : Medical School
Plan : Medicine M D

- - - - - Beginning of Medicine Record - - - - -

Fall Quarter 1998
University of Minnesota, Duluth
School of Medicine, Duluth
Medicine Major

Course		Description	Attempted	Earned	Grade	Points
ANAT	5504	Human Gross Anatomy	10.00	10.00	O	
BHSC	5211	Medical Sociology	2.00	2.00	P	
BHSC	5230	Med Psy:Interview	2.00	2.00	E	
FMED	5121	Preceptorship I	1.00	1.00	P	
MED	5520	Prin Basic Sci	13.00	13.00	E	
	TERM GPA : 0.000	TERM TOTALS :	28.00	28.00		0.000

Winter Quarter 1999
University of Minnesota, Duluth
School of Medicine, Duluth
Medicine Major

Course		Description	Attempted	Earned	Grade	Points
BHSC	5301	Bio/Epi	2.00	2.00	S	
FMED	5122	Preceptorship I	1.00	1.00	P	
MED	5510	Histopath	9.00	9.00	E	
MED	5541	Hemat,Host Def	11.00	11.00	S	
	TERM GPA : 0.000	TERM TOTALS :	23.00	23.00		0.000

Spring Quarter 1999
University of Minnesota, Duluth
School of Medicine, Duluth
Medicine Major

Course		Description	Attempted	Earned	Grade	Points
BHSC	5562	Hum Behav Devel,Pro	6.00	6.00	S	
FMED	5101	Fmed I	3.00	3.00	P	
FMED	5105	Physical Diagnosis	4.00	4.00	P	
FMED	5123	Preceptorship I	1.00	1.00	P	
FMED	5500	Cpc	1.00	1.00	P	
MED	5566	Cardiovasc Syst	10.00	10.00	E	
	TERM GPA : 0.000	TERM TOTALS :	25.00	25.00		0.000

1 Summer Quarter 1999
University of Minnesota, Duluth
School of Medicine, Duluth
Medicine Major

Course		Description	Attempted	Earned	Grade	Points
BHSC	5701	Med Ethics	2.00	2.00	E	
MED	5573	Nerv Syst	18.00	18.00	E	
	TERM GPA : 0.000	TERM TOTALS :	20.00	20.00		0.000

Effective Fall 1999 the University of Minnesota converted to semesters

Fall Semester 1999
University of Minnesota, Duluth
School of Medicine, Duluth
Medicine Major

Course		Description	Attempted	Earned	Grade	Points
BHSC	6200	Behav Med	2.00	2.00	E	
FMED	6441	Clin Rds,Clerk I	2.00	2.00	P	
FMED	6461	Preceptorship III	1.00	1.00	P	
MED	6724	GI Hepato Syst	6.00	6.00	E	
MED	6728	Respir Syst	5.00	5.00	E	
MED	6746	Fluid,Electytes	4.00	4.00	E	
	TERM GPA : 0.000	TERM TOTALS :	20.00	20.00		0.000

Spring Semester 2000
University of Minnesota, Duluth
School of Medicine, Duluth
Medicine Major

Course		Description	Attempted	Earned	Grade	Points
BHSC	5591	Std Med Behav Sci	2.00	2.00	P	
BHSC	6260	Psy Soc Aspect III	2.00	2.00	O	
FMED	6442	Clin Rds,Clerk II	2.00	2.00	P	
FMED	6462	Preceptorship IV	2.00	2.00	P	
FMED	6502	Clin Pathol Conf II	1.00	1.00	P	
MED	6762	Endocr,Reprod Syst	10.00	10.00	E	
MED	6773	Integr Clin Med	6.00	6.00	S	
MED	6788	Dermatol,M/S Syst	4.00	4.00	E	
	TERM GPA : 0.000	TERM TOTALS :	29.00	29.00		0.000

Summer Semester 2000
University of Minnesota, Twin Cities
Medical School
Medicine Major

Course		Description	Attempted	Earned	Grade	Points
OBST	7500	Ob/Gyn Externship	6.00	6.00	E	
OTOL	7200	Surg Spec: Otol	2.00	2.00	P	
UROL	7200	Urology Externship	2.00	2.00	P	
	TERM GPA : 0.000	TERM TOTALS :	10.00	10.00		0.000

Federation Credentials Verification Service
Federation of State Medical Boards
PO Box 619850
Dallas, TX 75261-9459

Susan Van Voorhis, Registrar
University of Minnesota - Twin Cities

University of Minnesota, Twin Cities

Name : Isley,Michelle Marie
Student ID: 1891871
Birthdate : 09-27

Fall Semester 2000

University of Minnesota, Twin Cities
Medical School
Medicine Major

Course		Description	Attempted	Earned	Grade	Points
FPCH	7501	Rural Physician Assoc Program	6.00	6.00	E	
FPCH	7501	Rural Physician Assoc Program	6.00	6.00	E	
MED	7500	Med I Externship	6.00	6.00	O	

TERM GPA : 0.000 TERM TOTALS : 18.00 18.00 0.000

Spring Semester 2001

University of Minnesota, Twin Cities
Medical School
Medicine Major
Rural Physician

Course		Description	Attempted	Earned	Grade	Points
FPCH	7501	Rural Physician Assoc Program	6.00	6.00	O	
FPCH	7501	Rural Physician Assoc Program	6.00	6.00	O	
FPCH	7501	Rural Physician Assoc Program	6.00	6.00	O	

TERM GPA : 0.000 TERM TOTALS : 18.00 18.00 0.000

Summer Semester 2001

University of Minnesota, Twin Cities
Medical School
Medicine Major
Rural Physician

Course		Description	Attempted	Earned	Grade	Points
FPCH	7501	Rural Physician Assoc Program	6.00	6.00	H	
INMD	7555	Elec Away	4.00	4.00	H	

Rural Physicians Associate Program fulfilled the requirements for SURG 7500
Rural Physicians Associate Program fulfilled the requirements
for Primary Care Clerkship INMD 7508/7509

TERM GPA : 0.000 TERM TOTALS : 10.00 10.00 0.000

Fall Semester 2001

University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
ADPY	7500	Psychiatry Externship	6.00	6.00	H	
MED	7501	Med II Externship	6.00	6.00	E	

TERM GPA : 0.000 TERM TOTALS : 12.00 12.00 0.000

Spring Semester 2002

University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
MED	7521	Infect Dis Elec	4.00	4.00	H	
NEUR	7510	Neurology Extrnship	4.00	4.00	E	
PED	7501	Pediatric Externship	6.00	6.00	E	

TERM GPA : 0.000 TERM TOTALS : 14.00 14.00 0.000

University of Minnesota Summary Information

Medicine Career Totals

			Attempted	Earned	Points
UMN GPA :	0.000	UMN TOTALS :	195.01	195.01	0.000
GPA UNITS :	0.000	CUM TOTALS :	195.01		

***** End of Transcript *****

Susan Van Voorhis, Registrar
University of Minnesota - Twin Cities

KEY TO TRANSCRIPT

Academic Calendar

The semester system started Fall 1999 for all University of Minnesota campuses. Prior to Fall 1999 the University used a quarter system with these exceptions: Law school started on semesters Fall 1981, and some College of Continuing Education courses were taught on a semester calendar but the credits reported as quarter credits.

Accreditation

The University of Minnesota is accredited by the North Central Association of Colleges and Secondary Schools, by the National Council for the Accreditation of Teacher Education, and by many other agencies.

Course (Class) Numbering System (from Fall 1999)

0000 to 0999 noncredit courses

1000 to 1999 primarily for undergraduates in first year

2000 to 2999 primarily for undergraduates in second year

3000 to 3999 primarily for undergraduates in third year

4000 to 4999 primarily for undergraduates in fourth year, may count for graduate credit if taught by a faculty member authorized to teach at the graduate level and with approval of student's major field.

5000 to 5999 primarily for graduate students but third and fourth year undergraduates may enroll

6000 to 7999 for postbaccalaureate professional degree students

8000 to 9999 for graduate students

Prior Course numbering systems

For Fall 1970 through Summer 1999 (course numbering prior to 1970 is noted in parenthesis):

0000 to 0999 noncredit courses

1000 to 1999 (01 - 49) introductory courses primarily for freshmen and sophomores

3000 to 3999 (50 - 99) intermediate courses primarily for juniors and seniors

4000 to 5999 (100 – 199) advanced courses for juniors, seniors and graduate students

8000 to 8999 (200 and higher) for graduate and professional school students

Credit

Starting Fall 1999 – units are semester credit

Prior to Fall 1999 – units generally are quarter credit (see calendar for exceptions)

Thesis credit – an asterisk (*) will appear following the course title of courses numbered 8777, 8888, or 8999 if the degree award is shown

An asterisk (*) indicates graduate credit taken though College of Continuing Education (Continuing Education and Extension prior to Fall 1999)

Grading Definitions

A – achievement that is outstanding relative to the level necessary to meet course requirements

B – achievement that is significantly above the level necessary to meet course requirements

C – achievement that meets the course requirements in every respect

D – achievement that is worthy of credit even though it fails to meet fully the course requirements

E – achievement that is significantly greater than the level required to meet the basic course requirements but not judged to be outstanding

F (or N) – Represents failure (or no credit) and signifies that the work was either (1) completed but at a level of achievement that is not worthy of credit or (2) was not completed and there was no agreement between the instructor and the student that the student would be awarded an I (see also I)

H – (Honors) Used by Law School and Medical School only

I – (Incomplete) Assigned at the discretion of the instructor when, due to extraordinary circumstances, e.g., hospitalization, a student is prevented from completing the work of the course on time. Requires a written agreement between instructor and student

K – assigned by an instructor to indicate the course is still in progress and that a grade can not be assigned at the present time

NG – no grade required

O – represents outstanding achievement for Doctor of Medicine and Doctor of Veterinary Medicine programs

P – achievement designating passing work

Q – achievement designating passing work

R – a course related registration symbol

S – achievement that is satisfactory, which is equivalent to a C- or better (C or better on the Duluth campus)—achievement required for an S is at the discretion of the instructor but may be no lower than a C- (no lower than a C on the Duluth campus)

T – transfer credit or test credit

V – registration as an auditor or visitor (a non-grade non-credit registration)

W – entered by the registrar's office when the student officially withdraws from a course after the second week

X – reported by the instructor for a student in a sequence course where the grade can not be determined until the sequence is complete – the instructor is to submit a grade for each X when the sequence is complete

Y – assigned from Fall 1929 to Summer 1959 to indicate the student canceled while doing passing work

Z – assigned from Fall 1929 to Summer 1959 to indicate the student canceled while doing failing work

On the Twin Cities campus from Fall 1972 through Summer 1977 and on the Morris campus from Fall 1972 through Summer 1985, the official University transcript included only positive academic achievements. Courses in which the student received a grade of N or a registration symbol of I or W did not appear on the transcript.

For complete grading policy, see
http://www.umn.edu/usenate/policies/gradingpolicy.html

Grade/Numeric Point Average Formula

Effective Fall 1997: grade point values were standardized for the University. All units except Law use: A = 4.000, A- = 3.667, B+ = 3.333, B = 3.000, B- = 2.667, C+ = 2.333, C = 2.000, C- = 1.667, D+ = 1.333, D = 1.000, D- = 0.000, F = 0.000, I = 0.000, K = 0.000, X = 0.000

Before 1997, most units did not use +/-. But the Duluth campus and the School of Management used: A = 4.0, A- = 3.6, B+ = 3.3, B = 3.0, B- = 2.6, C+ = 2.3, C = 2.0, C- = 1.6, D+ = 1.3, D = 1.0, F = 0.0 and the Twin Cities General College used A = 4.0, A- = 3.6, B = 3.2, B- = 2.8, C+ = 2.4, C = 2.0, C- = 1.6, D = 1.2, D- = 0.8, F = 0.0

The Twin Cities campus Law School uses a numeric rather than a grade point average for the *juris doctor (J.D.)* degree program. Grades range from 4-16 points based on the following:

14-16: Excellent/Outstanding; 11-13: Substantially better than average; 8-10: Minimally acceptable; 5-7: Inadequate (credits count towards degree completion, and NPA); 4: Failing; 0: Non-performance. Classes for which a 0 grade is earned are not included in NPA calculation. Grades earned in the *LL.M.* (Master of Laws) program are: A=4.00, B=3.00, C=2.00, D=1.00, F=0.00. No +/- distinctions are given.

Symbols Following Course Numbers

C – certificate credit

E – on Duluth campus, registration in Continuing Education, or on Twin Cities campus, an MBA course

G – honors course for extra credit

H – honors course

J – evening MBA course for extra credit

K – evening MBA course by independent study

L – honors course by independent study

M – extra credit by independent study

Q – evening MBA extra credit by independent study

R – honors extra credit by independent study

S – semester registration (pre 1999)

T – semester honors course (pre 1999)

U – special term course taken for extra credit

V – honors and writing intensive

W – writing intensive

X – extra credit

Y – independent study

Z – special term registration

Repeated course and re-enrollment eligibility vary by academic unit.
Degree with distinction indicates graduation with high GPA; degree with honors (laude) indicates completion of special honors program.
For more information see: **http://www.umn.edu**

Campus Records office locations:

University of Minnesota, Crookston
170 Owen Hall
Crookston, MN 56716-5001
(218) 281-8548
Dept. of Educ. Inst cd: 004069

University of Minnesota, Duluth
184 Darland Administration Building
Duluth, MN 55812-3011
(218) 726-8000
Dept. of Educ. Inst cd: 002388

University of Minnesota, Morris
212 Behnler Hall
Morris, MN 56267-2134
(320) 589-6030
Dept. of Educ. Inst cd: 002389

University of Minnesota, Twin Cities

200 Fraser Hall
Minneapolis, MN 55455-0213
(612) 624-1111
Dept. of Educ. Inst cd: 003969

or 130 Coffey Hall
St. Paul, MN 55108-1030
(612) 624-3731

or 130 West Bank Skyway
Minneapolis, MN 55455-0427
(612) 626-9110

The University of Minnesota, Waseca campus closed in 1992. For information on Waseca student transcripts, contact the St. Paul office.

University of Minnesota

The Regents of the University of Minnesota, upon recommendation of the faculty of the Medical School, confer upon

Michelle Marie Isley

the degree of

Doctor of Medicine

with all its privileges and obligations.

In the spirit of Hippocrates, this degree is granted to a person well qualified in the study, discipline, art, and science of medicine.

Given at Minneapolis, in the State of Minnesota, this eleventh day of May, two thousand-two.

Secretary, Board of Regents

Dean of the Medical School

UNIVERSITY OF MINNESOTA

President

Senior Vice President for Health Sciences

This is certified to be a true copy of the diploma issued to Michelle M. Isley by the University of Minnesota Medical School on May 11, 2002.

Helene M. Horwitz, Ph.D.
Associate Dean of Student Affairs

SEAL VERIFIED

Section IV

Postgraduate Training

F[redacted]ation Credentials Verification Service (FC[redacted]
Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **Ohio State University Hospital**
Address: Department of Obstetrics and Gynecology, Columbus, OH 43210-1228
Attention: Program Director
Affiliated University: _____

Verification For:
Name: **Isley, Michelle Marie**
SSN: [redacted]
DOB: 09/27/1974
Individual's Name on Record (If different from above): _____

RECEIVED JUN 11 2004 BY

Program Participation:
Important: Report Incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1
___ Internship
✓ Residency
___ Chief Residency
___ Fellowship
___ Research
Specialty/Subspecialty: OB/GYN
From: 7/1/02 To: 6/30/03
Successfully Completed?: ✓ Yes ___ No ___ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: 2
___ Internship
✓ Residency
___ Chief Residency
___ Fellowship
___ Research
Specialty/Subspecialty: (6)
From: 7/1/03 To: ___/___/Prog yr
Successfully Completed?: ___ Yes ___ No ✓ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: _____
___ 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:
Circle the correct response. Omitted responses require written explanation.

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

SEAL VERIFIED

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

Please explain any "Yes" response from above: _____

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

NOTARIAL SEAL STATE OF OHIO — TRACY L. JANOSIK, Notary Public, State of Ohio, My Commission Expires 04-01-06

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

Name: Philip Samuels, MD Signature: Philip Samuels
Title: Residency Prog. Director Date of Signature: 6-4-04
Tel: 614-293-3773 Fax: 614-293-5877 E-Mail: samuels.8@osu.edu

Subscribed and sworn before me this 4th day of June, 2004. Tracy L. Janosik

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, TX 75261-9850
Telephone (817) 868-5000
FAX: (817) 868-5099

URGENT

Fax Cover Sheet

TO: **Dr. Philip Samuels, MD**
Department of Obstetrics and Gynecology
Ohio State University Hospital
F - 614-293-5877

DOCUMENTS CRITICAL FOR MEDICAL LICENSURE

PLEASE EXPEDITE

DATE: June 17, 2004

FROM: Danna Alexander
dalexander@fsmb.org
P – 817-868-5085

Packet ID: 41444
Request ID: 13364980
Michelle Marie Isley, MD

The form you recently submitted to FCVS for **Dr. Isley** was either incomplete or requires further clarification.

Please address these items listed below and return by fax to 817-868-4213.

Please mail a hard copy of your changes to my attention.

1. Please report the name of the department that oversaw the postgraduate training for the above named individual during PGY 2 Residency from 07/01/2003 to present.

   Department: OB/GYN

2. Please indicate below the expected date of completion for PGY 2 Residency.

   Date postgraduate year complete 6/30/2004

Completion of the following is certification that the information above is an accurate account of the individual's records and is true and correct. **This section MUST be signed by the Program Director (MD/DO only) or an appropriate representative.**

Philip Samuels / Residency Prog. Director / 6-18-04

Signature / Title / Date

Number of Pages Sent: 1

PROVIDED BY APPLICANT

Applicant: Print your complete last name: Isley

20. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. **Use one page per institution.**

You are provided two pages (p. 7 - 8) in this application to report this information. You must make a photocopy(ies) of this page to report more than two (2) institutions.

IMPORTANT:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If your postgraduate year is currently in progress, indicate the *expected* completion date in the "To" field.

Report internships, residencies, fellowships and research programs separately.

Use one section per department.

(PGY) - Postgraduate years is also known as postgraduate training level.

If a break of six (6) months or more occurred between any of your postgraduate training activities, please provide a written explanation outlining your activities during this "gap" period on the enclosed Gap Explanation Form.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8.5" x 11" sheet of paper. Your response may not exceed 100 words per question.

Use one (1) page per institution. This page represents 1 of 1 institution(s).

THE OHIO STATE UNIVERSITY MEDICAL CENTER
Complete name of hospital where training was conducted (Do not abbreviate)

THE OHIO STATE UNIVERSITY
Complete name of affiliated university or college (Do not abbreviate)

Address line 1

Address line 2

COLUMBUS — City
OH — State/Province
USA — Country
ZIP/Postal Code

PGY: 1
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
OBSTETRICS/GYNECOLOGY — Specialty/subspecialty
From: 06 2002 (Month Year) To: 06 2003 (Month Year)
Successfully Completed? ☒ Yes ☐ No ☐ In progress

PGY: 2
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
OBSTETRICS/GYNECOLOGY — Specialty/subspecialty
From: 06 2003 (Month Year) To: 06 2004 (Month Year)
Successfully Completed? ☐ Yes ☐ No ☒ In progress

PGY: ____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/subspecialty
From: ____ ____ (Month Year) To: ____ ____ (Month Year)
Successfully Completed? ☐ Yes ☐ No ☐ In progress

PGY: ____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/subspecialty
From: ____ ____ (Month Year) To: ____ ____ (Month Year)
Successfully Completed? ☐ Yes ☐ No ☐ In progress

Unusual Circumstances (circle yes or no):

Did you ever take a leave(s) of absence or break(s) from 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 ever filed against you?	Yes (No)
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	Yes (No)

Please explain any "Yes" responses from above: ____

Section V

Examination History/Score Transcripts

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

USMLE United States Medical Licensing Examination™

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 06/01/2004

Federation Credentials Verification Service
ATTN: Ohio

Packet ID: 41444

Examinee: Isley, Michelle Marie
USMLE ID#: 5-078-504-7
DOB: 09 / 27 / 1974
Alt Name(s):

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	6/2/2000	PASS	208	(179)	84	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	12/22/2001	PASS	208	(174)	84	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
OHIO	9/26/2003	PASS	189	(182)	77	(75)	

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

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

Date Posted: 6/26/2006 8:00:43 AM

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

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

Address Information

CREDENTIAL MAIL ADDRESS	Oregon Health & Sciences University Attn: Neil Berry 2241 Lloyd Center Portland, OR 97232 Out of State County United States of America 503-494-4072
CREDENTIAL MAIL ADDRESS	Oregon Health & Sciences University 2241 Lloyd Center, Attn: Neil Berry Portland, OR 97232 Out of State County United States of America 503-494-4072
MAIN	1424 SE 24th AVE Portland, OR 97214 Out of State County United States of America 503-494-4473

License Information

License Number	35.085199
License Name	Michelle Isley
Email Address	

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . 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.**

. . . . . N/A

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: 5/27/2008 12:36:03 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.

License Information

License Number	35.085199
License Name	Michelle Isley
Email Address	mmisley@hotmail.com

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

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

against you?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . 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: 5/6/2010 10:14:25 PM

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

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

Address Information

CREDENTIAL MAIL ADDRESS	201 Aldrich Rd Columbus, OH 43214 Franklin County United States of America 614-404-8663 mmisley@hotmail.com
CREDENTIAL MAIL ADDRESS	201 Aldrich Rd Columbus, OH 43214 Franklin County United States of America 614-404-8663
MAIN	201 Aldrich Rd Columbus, OH 43214 Franklin County United States of America 614-404-8663 mmisley@hotmail.com

License Information

License Number	35.085199
License Name	Michelle Isley

Fees

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

Specialty Codes

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

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . 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: 9/5/2012 9:56:47 AM

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

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

Address Information

CREDENTIAL MAIL ADDRESS

201 Aldrich Rd
Columbus, OH 43214
Franklin County
United States of America
614-404-8663
Michelle.Isley@osumc.edu

License Information

License Number 35.085199
License Name Michelle Isley

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received

treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Baumann, Maryls, CNP; Beier-Phillips, Stephanie, CNP; Buechner, Dana, CNP; France Kremin, Holly, CNP; Gray, Temeaka, CNP; Holzer, Lesely, CNP; Quinlan, Colleen, CNP; Shanks, Alicia, CNP; Strzesynki, Caroline, CNP; Taylor, Joanna, CNP; Wright, Angela, CNP; Kheirkhah, Shonna, CNM; Berg, Cara, CNP; Brooks, Latina, CNP; Caswell, Annie, CNP; Darnell, Debbie, CNP; DelCiappo, Linda, CNM; Dudziak, Valerie, CNP; Erinakes-Chauvette, CNM; Friedman, Jean, CNP; Gallagher, Rachel, CNM; Hallock, Laura, CNP; Halter, Sarah, CNM; Hetrick, Pam, CNM; Howman, Lauren, CNP; Knudtsen, Jeanne, CNM; Melver, Ginny, CNP; Meredith, Michelle, CNP; Molnar, Diane, CNP; Nowicki, Mary, CNM; Palajac, Jill, CNP; Peterson, Jane, CNP; Pustelnik, Iola, CNM; Rackow, Connie, CNP; Riley, Shannon, CNP; Tabin, Jennifer, CNM;

Trivisonno, Teri, CNP; Wilforc, Emily, CNP; Yunck, Louise, CNM

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 25-29

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

. 1-4

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

. 5-9

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

. 1-4

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

. 0

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

. 1-4

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)".

. 5-9

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

. 0

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

. 0

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

. 5-9

Workforce Counties

1. Enter the first zip code:

. 43210

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. 43215

4. Enter the second county:

. . . . . Franklin

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.

. . . . . 2020 Kenny Rd, Columbus, OH 43210; 206 East State St, Columbus, OH 43215

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

Workforce Language Question

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

. . . . . 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: 7/20/2014 4:05:42 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	35.085199
License Name	Michelle Isley

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . 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

. 30-34

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

setting or for a medical purpose

. 1-4

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

. 10-14

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

. 20-24

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)".

. 5-9

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 43210

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1437256203

DEA number

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

. . . . . BI9613185

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.