



**MEDICAL BOARD OF CALIFORNIA**

LICENSING PROGRAM  
 1428 Howe Avenue, Suite 54  
 Sacramento, CA 95825-3236  
 (916) 263-2382 FAX (916) 263-2487  
 www.calcdceinfo.ca.gov

RECEIVED  
 MEDICAL BOARD OF  
 CALIFORNIA



06 NOV -2 PM 1:02

**INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE  
 OR POSTGRADUATE TRAINING AUTHORIZATION LETTER**

Application for (please check one):  License  PTAL - or -  Update

1. NAME: Last Schutt-Aine First Ann Middle Irene

Other names you have used (include maiden name): \_\_\_\_\_

2. U.S. Social Security Number: \_\_\_\_\_

3. Place of Birth: Cheverly, Maryland, USA

4. Date of Birth: \_\_\_\_\_

5. Gender:  Male  Female

6. Public/Mailing Address: 513 Arthur Street  
 (Please note: this information is public)  
 (30 characters maximum per line, including spaces)

City: Pittsburgh State/Province: PA Zip/Postal Code: 15219 Country: USA

7. Telephone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

8. California Driver's License Number (optional): \_\_\_\_\_

9. E-mail Address (optional): \_\_\_\_\_

10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California?  
 Yes  No  
 Previous license number, if any: \_\_\_\_\_

**MEDICAL EDUCATION**

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
Harvard Medical School	Boston, MA USA	9/96 - 6/00

School of Graduation	Degree Awarded	Date of Graduation
Harvard Medical School	Doctor of Medicine	June 2000

**EXAMINATIONS**

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN:

USMLE, FLEX, NBME, ECFMG, SPEX,  
 STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)
USMLE-Step 1	June 1998	
USMLE-Step 2	December 10, 1999	
USMLE-Step 3	January 21, 2001	

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

**ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING**

14. Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.

Facility Name	Address	Specialty Area	Dates of Attendance
Magee-Womens Hospital of the University of Pittsburgh Medical Center	300 Halket Street Pittsburgh, PA 15219	Obstetrics/Gynecology	June 2000 - June 2004

**POSTGRADUATE TRAINING** (These questions are to be answered by ALL applicants)

- Did you ever take a leave of absence or break from your training? YES NO
- Have you ever been terminated, dismissed or expelled from a program? YES NO
- Have you ever resigned from a training program? YES NO
- Were you ever placed on probation? YES NO
- Were you ever disciplined or placed under investigation? YES NO
- Were any incident reports ever filed by instructors? YES NO
- Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason? YES NO
- Have you ever had a postgraduate training program contract not be renewed or offered for a following year? YES NO

**MEDICAL LICENSURE**

15. Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
Pennsylvania	MD419734	6/14/2002	June 2004 - present

APPLICANT: Schutt-Ainé, Ann I.

DATE OF BIRTH:

**L1E**





Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, Ann J. Schutt-Aine (PLEASE PRINT FULL NAME) \_\_\_\_\_ (DATE OF BIRTH) \_\_\_\_\_ being first duly sworn upon his/her

oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

(PLEASE INITIAL BOX)

SIGNATURE OF APPLICANT: Ann Schutt-Aine

State of Pennsylvania (Please sign full name)

County of Allegheny

Subscribed and sworn to (or affirmed) before me on

this 19 day of October, 2006

by Ann J. Schutt-Aine

personally known to me or proved to me on the basis of satisfactory evidence to be the person who appeared before me.

NOTARY SEAL

COMMONWEALTH OF PENNSYLVANIA

Claire E. Williams, Notary Public  
City of Pittsburgh, Allegheny County  
My Commission Expires Apr. 8, 2010  
Member, Pennsylvania Association of Notaries

Claire E. Williams  
SIGNATURE OF NOTARY PUBLIC



## ABMS CERTIFICATIONS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES  NO

Member Board	Expiration Date	Certificate Number
American Board of Obstetrics and Gynecology	sitting for exam Dec. 2006	

## MALPRACTICE HISTORY

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of \$30,000 or more? YES  NO

## PRACTICE IMPAIRMENT OR LIMITATIONS

- |  |     |    |
|--|-----|----|
| 18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? | YES | NO |
| 19. Have you been treated for or had a recurrence of a diagnosed addictive disorder?   | YES | NO |
| 20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely?          | YES | NO |
| 21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely?     | YES | NO |
| 22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely?                                 | YES | NO |

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

## CRIMINAL RECORD HISTORY

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction or disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application.

YES  NO

**APPLICANT:**

Schutt-Ainé, Ann I.

**DATE OF BIRTH:**

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# CRIMINAL RECORD HISTORY (cont'd)

- |   |     |    |
|---|-----|----|
| 24. Is any criminal action pending against you?     | YES | NO |
| 25. Are you required to register as a Sex Offender? | YES | NO |

## DISCIPLINARY HISTORY

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

- |   |     |    |
|---|-----|----|
| 26. Have you ever been denied a license to practice medicine?   | YES | NO |
| 27. Is any denial pending against you?  | YES | NO |
| 28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital? | YES | NO |
| 29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?  | YES | NO |
| 30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?                         | YES | NO |
| 31. Have you ever had any license to practice medicine subjected to any other disciplinary action?  | YES | NO |
| 32. Is any disciplinary action pending against any of your licenses to practice medicine?   | YES | NO |
| 33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?   | YES | NO |
| 34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?   | YES | NO |
| 35. Is any disciplinary action pending against your hospital staff privileges?  | YES | NO |
| 36. Have you ever surrendered a license to practice medicine?   | YES | NO |
| 37. Have your DEA privileges ever been denied, suspended, restricted, or terminated?  | YES | NO |
| 38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?   | YES | NO |

APPLICANT:

Schutt Aine, Ann J.

DATE OF BIRTH:

L1D





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 06 DEC 27 AM 10:03  
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**CERTIFICATE OF MEDICAL EDUCATION**

**MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE**

This certifies that Ann D. Schutt-Aue, Full Name of Applicant, U.S. Social Security Number \_\_\_\_\_, enrolled in Harvard Medical School, Name of Medical School, located in Boston, MA, State/Province/Country, on 09/03/1996, Enrollment Date.

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2) and that the applicant

- |   |  |  |
|---|--|--|
| Anatomy                                 | Embryology                                 | Physical Medicine                            |
| Otolaryngology                          | Histology                                  | Therapeutics                                 |
| Obstetrics and Gynecology               | Human Sexuality                            | Neuroanatomy                                 |
| Radiology, including Radiation Safety   | Medicine                                   | Child Abuse Detection and Treatment          |
| Tropical Medicine                       | Surgery, including Orthopedic Surgery      | Geriatric Medicine                           |
| Physiology                              | Urology                                    | Pediatrics                                   |
| Biochemistry                            | Psychiatry                                 | Pharmacology                                 |
| Pathology, Bacteriology, and Immunology | Neurology                                  | Anesthesia                                   |
| Ophthalmology                           | Alcoholism and Chemical Dependency         | Spousal Partner Abuse Detection & Treatment* |
| Dermatology                             | Preventative Medicine, including Nutrition | Family Medicine**                            |
|   |  | Pain Management and End-of-Life-Care***      |

\* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.  
 \*\* ONLY applicable to medical students who graduate from medical school on or after May 1, 1998.  
 \*\*\* ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000.

was granted the degree of Bachelor/Doctor of Medicine on the 8 day of June, 2000.  
 withdrew from medical school on \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Unusual Circumstances

Responses

Did this individual ever take a leave of absence from their medical education?	Yes	No
Was this individual ever placed on probation?	Yes	No
Was this individual ever disciplined or under investigation?	Yes	No
Were any incident reports regarding this individual ever filed by instructors?	Yes	No
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes	No

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

<p>Medical School Seal Must Be Imprinted Below</p>	<p>Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.</p> <p>Signed and the school seal affixed this <u>20</u> day of <u>December</u>, 2006</p> <p>By: <u>Terese Galuszka, Registrar</u>  <small>Printed Name and Title of School Official</small></p> <p>Signature: <u><i>Terese Galuszka</i></u></p>
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06 DEC 12 AM 9:32



LICENSING PROGRAM

**CERTIFICATE OF COMPLETION OF ACGME/RCPC POSTGRADUATE TRAINING**

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

**PART 1: TO BE COMPLETED BY THE APPLICANT**

NAME: Last <i>Schutt Aine</i> ✓			First <i>Ann</i>			Middle <i>A</i>		
U.S. Social Security Number			Date of Birth			Telephone Number		
Home			Work					
Public/Mailing Address <i>513 Arthur Street</i>								
City <i>Pittsburgh</i>			State/Province <i>PA</i>			Zip/Postal Code <i>15219</i>		
Medical School of Graduation: <i>Harvard Medical School</i>								

**PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR**

**ATTENTION PROGRAM DIRECTOR:** Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility: <i>UNIVERSITY OF PITTSBURGH MEDICAL CENTER</i>		ACGME 10 digit Program number: (www.acgme.org) <i>2204111258</i>	
<i>MEDICAL EDUCATION PROGRAM</i>			
Address of Facility: <i>300 HALKET ST</i>		Telephone #: <i>412-641-1674</i>	
<i>MAGEE-WOMENS HOSPITAL 76H, PA 15213</i>			
Categorical Specialty Area of Training <i>OB/GYN</i>	Start Date of Training <i>06/21/2000</i>	End-Date (or anticipated completion date) of Training <i>06/20/2004</i>	

**UNUSUAL CIRCUMSTANCES:**

Did the trainee ever take a leave of absence or break from their training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

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## DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

**"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILITY FOR PATIENT CARE.**

## GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.


I hereby certify as the program director, that the individual named in Part 1

has completed  has not completed

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

  
SIGNATURE OF PROGRAM DIRECTOR

**ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.**

HOSPITAL SEAL	OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING
	<p>The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.</p> <p><u>GABRIELLA G. GOSMAN MD</u> PRINT NAME OF PROGRAM DIRECTOR</p> <p> SIGNATURE OF PROGRAM DIRECTOR Signature Stamp Is Not Acceptable</p> <p><u>11/21/06</u> DATE SIGNED</p>

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed and sworn to (or affirmed) before me on

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

by \_\_\_\_\_

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

\_\_\_\_\_  
SIGNATURE OF NOTARY PUBLIC

**L3B**