MB64048

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration

PROCESSED 2012 AUG 13 AM 8 47

BOARD OF MEDICINE

NSE APPLICATION FOR MEDICINE AND OSTEOPATHY (MD & DO)

:tion of this application and submit the original application and all required supporting documents. If more space :ach additional sheets with typed responses. False or misleading statements will be cause for disciplinary prosecution pursuant to *DC Code 22-2514*. If you have any questions, call HPLA Customer Service at :lay, 8:15AM to 4:40PM EST.

YPE & FEES

SELECT LICENSURE TYPE:

- ☑ Medicine & Surgery (MD)
- ☐ Osteopathy & Surgery (DO)

SELECT GRADUATE TYPE:

- ☑ U.S./ Canadian Graduate
- ☐ International Graduate

SECTION 1B. BASIS OF APPLICATION

Select the basis by which you are applying:

EXAM COMPLETED: $805.00

☑ USMLE ☐ NBME ☐ NBOME ☐ LMCC
☐ FLEX ☐ COMLEX ☐ COMVEX ☐ State Exam

USMLE STEP 3: ☐ Exam $288.00 ☐ Re-Exam $85.00

EMINENCE:
☐ Eminence 1: $805.00 ☐ Eminence 2: $2000.00

SECTION 2A. APPLICANT INFORMATION

Note: LEGAL NAME: *(Do not use any initials unless they are a part of your name)*

OLUWAFUNMILOLA	T	BADA	
FIRST NAME	MI	LAST NAME	(SUFFIX: Jr., Sr. etc.)

DEGREE(S): ☑ M.D., ☐ D.O, ☐ PH.D., ☐ OTHER DEGREE ____________

Date of Birth ______ Social Security Number ______ GENDER: ☐ MALE ☑ FEMALE

SECTION 2B. OTHER NAMES USED: (Please print clearly)

If your name has changed at any point since you first registered with the American Medical Association, taken any exams or attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

FIRST NAME	MI	LAST NAME	(SUFFIX: Jr., Sr. etc.)
TEMITOPE		BADA	

Place of Birth : State/Providence/Territory ____________ Country if not USA ____________

SECTION 2C: RACE & ETHNICITY DESIGNATION: (Optional)

- ☐ American Indian/Alaskan Native
- ☐ Asian/South Asian
- ☑ Black or African American
- ☐ Caucasian/White
- ☐ Hispanic or Latino
- ☐ Other ____________
- ☐ Native Hawaiian or other Pacific Islander

LANGUAGE(S) SPOKEN:

Language(s) spoken other than English:

____
____
____

DEPARTMENT OF HEALTH Promote. Prevent. Protect.

BOARD OF MEDICINE

NEW LICENSE APPLICATION FOR MEDICINE AND OSTEOPATHY (MD & DO)

SECTION 3A. PREFERRED MAILING ADDRESS

Note: A P.O. BOX MAY NOT BE USED FOR AN ADDRESS. PLEASE PROVIDE A STREET ADDRESS.

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☒ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 3B. HOME ADDRESS

THIS INFORMATION WILL NOT BE MADE AVAILABLE TO THE PUBLIC.

HOME ADDRESS: ____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #__________ **HOME PHONE NUMBER:** ____________ **HOME FAX:** (_____) _____ - _______

EMAIL ADDRESS: ____

SECTION 3C. BUSINESS ADDRESS:

THIS INFORMATION WILL BE MADE AVAILABLE TO THE PUBLIC.

BUSINESS NAME: ____

BUSINESS ADDRESS: ____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

☐ **SUITE #**______________ ☐ **FLOOR#**______________

BUSINESS PHONE NUMBER: (_____) _____ - _______ **BUSINESS FAX:** (_____) _____ - _______

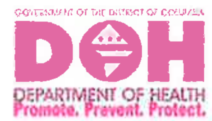
EMAIL ADDRESS: ____

IMPORTANT MESSAGE TO ALL PHYSICIANS

Physicians are required to update name or address changes within 30 days of the change. It is imperative that you update your information in writing, by email hpla.doh.dc.gov or fax (202) 724-5145 to the District of Columbia Health Professional Licensing Administration Processing Department. Submit your request to the Attention of the "Processing Center". Include your name, phone number and any other pertinent information that will assist us in ensuring that the information is updated to the appropriate record/file.

District of Columbia Health Professional Licensing Administration
Attention: Processing Department – Board of Medicine
899 North Capitol Street, N.E., 1st Floor
Washington, D.C. 20002

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration



BOARD OF MEDICINE

NEW LICENSE APPLICATION FOR MEDICINE AND OSTEOPATHY (MD & DO)

SECTION 4A. POST SECONDARY SCHOOLS ATTENDED

List post secondary schools attended, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Date of Graduation mm/yyyy	Degree/Certificate
HOWARD UNIVERSITY COLLEGE OF MEDICINE	06/2005	MD / BS

SECTION 4B. MEDICAL TRAINING AND MEDICAL PRACTICE – POSTGRADUATE EXPERIENCE

List experience covering the five (5) year period prior to the submission of the application (MONTH & YEAR) and all internship, residency, and fellowship training. Include letters from employing facilities, organizations, and training (internships, residencies, and fellowships). For "TRAINING AND PRACTICE DESCRIPTIONS", use the letter key code below. List experience in reverse chronological order, beginning with the most recent.

Organization/Institution	Start Date mm/yyyy	End Date mm/yyyy	Type of Position (Use Key Code Below)
METROPOLITAN WOMENS GROUP	08/2009		E
NEW YORK METHODIST HOSPITAL	07/2005	06/2006	~~C~~ error B
NEW YORK METHODIST HOSPITAL	07/2006	06/2009	C

TRAINING AND PRACTICE DESCRIPTIONS/TYPE OF POSITION KEY CODE

A. Fellowship B. Internship C. Residency D. Employment E. Private Practice
F. Other … (Attach a typed explanation on a separate sheet of paper to this form.)

SECTION 4C. MEDICAL LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a license (excluding training licenses) and provide letters of verification. Use additional sheet if necessary.

Are you currently applying for licensure in any other jurisdiction? NO If yes please list:________________

Jurisdiction	Issue Date mm/yyyy	Expiration Date mm/yyyy	License Number
MARYLAND	06/2009	09/2012	D69373

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration

BOARD OF MEDICINE

NEW LICENSE APPLICATION FOR MEDICINE AND OSTEOPATHY (MD & DO)

SECTION 5A. PRACTICE TIME IN THE DISTRICT

Please provide practice information

(1.A) Do you plan to practice in the District of Columbia? [X] Yes [ ] No

(1.B) What type of medical practice? [X] Academic [ ] Administrative [ ] Clinical [ ] Research

(1.C.) How many hours will you practice in the District of Columbia?	<less than 20 hours/week	>more than 20 hours/week
ACADEMIC MEDICINE		
ADMINISTRATIVE MEDICINE		
CLINICAL MEDICINE		
RESEARCH MEDICINE		

(2) Please indicate if you do or will practice in: [X] Maryland [ ] Virginia

SECTION 5B. SPECIALTIES

Please select the appropriate specialties.

If your practice is limited to a specialty, please indicate the code from the specialty code listed below. Primary OB

Secondary ______

SPECIALTY CODE

AC Academic Medicine
ADM Administrative Medicine
AI Allergy & Immunology
AN Anesthesiology
DE Dermatology
EM Emergency Medicine
FM Family Medicine
GE Geriatrics
HOS Hospitalist
IN Internal Medicine (General)
IN Internal Medicine
- IN/CA Cardiology
- IN/EN Endocrinology
- IN/GI Gastroenterology
- IN/HEM Hematology
- IN/ID Infectious Disease
- IN/NEP Nephrology
- IN/NEU Neurology
- IN/ONC Oncology
- IN/PCC Pulmonary Critical Care
- IN/PUD Pulmonary Disease
- IN/RH Rheumatology

MG Medicine Genetics

NU Nuclear Medicine
OB Obstetrics & Gynecology
OC Occupational Health
OP Ophthalmology
OMT Osteopathic Manipulative Treatment
ENT Otolaryngology
PA Pathology
PED Pediatrics (General)
PED Pediatrics
- PED/AD Adolescent Medicine
- PED/CA Cardiology
- PED/EN Endocrinology
- PED/GI Gastroenterology
- PED/HEM Hematology
- PED/NEO Neonatology
- PED/NEP Nephrology
- PED/NEU Neurology
- PED/ONC Oncology
- PED/PCC Pulmonary Critical Care
- PED/PUD Pulmonary Disease
- PED/RH Rheumatology

PMR Physical Medicine & Rehabilitation
PR Preventive Medicine/Public Health
PSY Psychiatry
RA Radiology
REM Research Medicine
SU Surgery (General)
SU Surgery
- SU/BT Burn/Trauma
- SU/CS Cardiac Surgery
- SU/CO Colon & Rectal Surgery
- SU/GE General Surgery
- SU/NE Neurological Surgery
- SU/OR Orthopedic Surgery
- SU/PL Plastic Surgery
- SU/TH Thoracic Surgery
- SU/TP Transplant
- SU/UR Urology
- SU/VA Vascular

Other: ______

BOARD CERTIFICATION(S)

Are you board certified in any specialty? [X] Yes [ ] No *(If yes please list in the provided space below)*

Please list certifying organization(s)

ABOG

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration

BOARD OF MEDICINE

NEW LICENSE APPLICATION FOR MEDICINE AND OSTEOPATHY (MD & DO)

SECTION 5C. REQUIRED SCREENING QUESTIONS

Please answer questions A through O by placing an X in the appropriate boxes. If you answer "YES" to any question, you must provide full information and complete details **on a separate sheet of paper attaching copies of all relevant documents such as final court orders or panel review decisions.**

	Question	Yes	No
A.	Have you ever been arrested, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor (including driving under the influence or while impaired, but excluding minor traffic violations)?	☐	☒
B.	Have you ever been licensed in any healthcare field in any state or jurisdiction? If yes, please list profession(s) & jurisdiction(s). **HEALTH PROFESSION(S)** ____ **JURISDICTION(S)** ____	☐	☒
C.	Have you been a defendant or respondent to a claim for damages or a malpractice action?	☒	☐
D.	Have you ever voluntarily surrendered a license or registration certificate (or allowed it to lapse) after formal charges had been brought against you or while you were under investigation?	☐	☒
E.	Have you ever surrendered your clinical privileges (voluntary or involuntary) or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	☐	☒
F.	Have you ever been terminated or resigned (voluntary or involuntary) from a clinical or professional training program for any reason?	☐	☒
G.	Has any licensing authority taken adverse action against your medical/osteopathy license or privileges or informed you of any pending charges?	☐	☒
H.	Has any licensing authority, health facility, or peer review board informed you of any pending charge(s) or investigation(s) against you?	☐	☒
I.	Are you presently or have you ever been under a corrective action plan imposed by an employer, medical facility or educational program?	☐	☒
J.	Do you have a medical condition or have you become aware of any medical condition that currently impairs or limits your ability to practice medicine safely or that could affect your performance or impact your ability to practice your profession?	☐	☒
K.	Are you currently being treated, or within the past five (5) years have you been treated, for a physical or mental condition that, but for the treatment, could impair your ability to practice your profession?	☐	☒
L.	Have you ever engaged in the excessive use of alcohol, controlled substances or prescription drugs or have you received treatment or therapy for abuse of alcohol or drugs?	☐	☒
M.	Within the last ten (10) years, have you voluntarily resigned, asked to resign, been terminated, or disciplined by any employer due to practice or moral turpitude issues?	☐	☒
N.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	☐	☒
O.	Have you ever had a professional liability policy cancelled or not renewed?	☐	☒

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration

DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

BOARD OF MEDICINE

NEW LICENSE APPLICATION FOR MEDICINE AND OSTEOPATHY (MD & DO)

SECTION 6A. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Keep a photocopy.

- ☑ Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back.
  The photos must be original photos and cannot be computer-generated copies or paper copies.
- ☑ Character reference form
  Please have form completed by each employer/training program within the past five years (No more than 3 required. Must be completed by an MD or DO).
- ☑ AMA/AOA Profile *The profile should be submitted from the issuing institution.*
- ☑ FCVS *(If applicable)*
- ☑ Verification(s) of licensure – *These should be provided in a sealed envelope from the issuing jurisdiction(s) for each license identified in Section 4C.*
- ☑ All undergraduate, graduate, medical, and professional school transcripts.
  Transcripts should be provided in a sealed envelope from the issuing institution for each school that you attended and listed in Section 4A.
- ☑ Documentation of all experience covering the five (5) year period prior to the submission of the application and all internships, residencies, and fellowship training.
  Proof of experience should be submitted as a letter on official letterhead from the overseeing institution/organization.
- ☑ Examination scores –*In a sealed envelope from the examination contractor or administrator.*
- ☐ ECFMG Certificate *(if Foreign applicant)*
- ☐ FMGEMS Certificate *(if Fifth Pathway applicant)*
- ☐ Eminence application package *(if Eminence 1 or 2 applicant)*
- ☑ Criminal Background Check (CBC) -*To access form and instructions go to www.hpla.doh.dc.gov/bomed or contact the CBC unit at 202.727.9855.*

SECTION 6B. CONTROLLED SUBSTANCE REGISTRATION

Will you be applying for a DC controlled substance license?

☑ **YES**

☐ **NO**

If yes, please visit the Pharmaceutical Control Division at www.hpla.doh.dc.gov/pcd or contact Karin Barron at 202.724.8938/Yvonne Briscoe-Hall at 202.442-5877

SECTION 6C. PAYMENT/MAILING INFORMATION

Make **CHECK** or **MONEY ORDER** payable to **DC Treasurer**:
A charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

MAIL YOUR APPLICATION PACKAGE AND CHECK TO:

Health Professional Licensing Administration
Board of Medicine – Processing Center –
899 North Capitol Street, NE (First Floor)
Washington, DC 20002

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration

BOARD OF MEDICINE

NEW LICENSE APPLICATION FOR MEDICINE AND OSTEOPATHY (MD & DO)

SECTION 7A.

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following:

Fines, penalties, or interest assessed pursuant to *D.C. Official Code Title 8, Chapter 8* (Litter Control Administrative Act of 1985);

Fines or interest assessed pursuant to *D.C. Official Code Title 8, Chapter 9* (Illegal Dumping Enforcement Act of 1994);

Fines, penalties, or interest assessed pursuant to *D.C. Official Code Title 2, Chapter 18* (Civil Infractions Act of 1985);

Past due taxes;

Past due District of Columbia Water and Sewer Authority service fees; or

Fines or penalties assessed pursuant to *D.C. Official Code Title 50, Chapter 23* (Traffic Adjudication)?

Yes ☐ **No** ☒

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (***D.C. Law 11-118, D.C. Code §47-2861 et seq.***).

SECTION 7B. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

[signature]	OLUWAFUNMILOLA T. BADA	08/6/12
LICENSEE SIGNATURE	*PRINT NAME*	*DATE*

I, Dr Oluwafunmilola T. Bada have been named as a co-defendant in a malpractice claim, which took place during my time as a resident at New York Methodist Hospital. The malpractice claim, Fall/Lugg v. New York Methodist Hospital et al, was filed through the Kings County Courts in Brooklyn, New York, as court case# 22083-9. The malpractice claim is against the hospital and all personnel involved in the care that allegedly resulted in an Erb's palsy on 11/23/2008. The insurance company CCC. Insurance Group has retained the law firm Furey, Kerley, Walsh, Matera & Cinquemani, P.C. to represent the legal interest of the hospital and all personnel involved. As of April 2012 legal papers have been served to the plaintiff's counsel to initiate a Preliminary Conference at which time matters of pretrial discovery will be addressed.

Rev. 10/11 MEDICINE & OSTEOPATHY

DC Department of Health
Board of Medicine Character Reference Form

Board of Medicine
899 North Capitol St., NE 1st Flr.
Washington, DC 20002

(202)-724 4900

Please print/type name and location of setting completing this form (Should match setting listed on chronological page of application)

Rebecca Rodesill M.D.
Metropolitan Women's Group - 1111 Spring Street Suite 220
Silver Spring MD 20910

Bada

Please clearly print/ type name of Applicant

The District of Columbia Board of Medicine, in its consideration of a candidate for licensure, depends on information from persons and institutions regarding the candidate's employment, training, affiliations, and staff privileges. Please complete this form to the best of your ability and return it to the board so the information you provide can be given consideration in the processing of this candidate's application in a timely manner. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and governmental agencies and instrumentalities (local, state, federal or foreign) to release to the D.C. Board of Medicine any information, files or records requested by the board in connection with the processing of my application.

Signature of Applicant ____________________

Item #1 must be completed, or form may be invalid

1. Date and type of service: This individual served with us as a colleague in a single specialty practice from 8/2009 (Month/Year) to present (Month/Year). If you are responding for a training program, please provide the number of months of postgraduate training awarded __________.

2. Please evaluate: (Indicate with check mark)

		Poor	Fair	Good	Superior
Professional knowledge					X
Clinical judgment					X
Relationship with patients					X
Ethical/professional conduct					X
Interest in work					X
Ability to communicate					X

3. To your knowledge, has the applicant been the subject of any disciplinary or legal proceeding convened by a state regulatory agency or board, employer hospital or health care facility? Yes☐; *(if yes, please explain on a separate sheet)* No☒

4. Recommendation: (please indicate with check mark)
   Recommend highly and without reservation ☒; Recommend as qualified and competent ☐
   Recommend with some reservation (explain) ____________________
   Do not recommend (explain) ____________________

5. Of particular value to us in evaluating any candidate regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you.
   Dr. Bada is highly committed to quality patient care. She is reliable, caring, and a great colleague!

6. The above report is based on: (please indicate with check mark)
   Close personal observation ☒; General impression ☐; A composite of evaluations ☐;
   Other: ____________________

Date (Required): 6/8/12

Signed by: RR
Print or type name: Rebecca Rodesill
Title: MD

HOWARD UNIVERSITY
Office of Enrollment Management
Washington, D.C.

Date Issued: 07-AUG-2012
WEB

Page: 1

Student No:

Record of: Temitope Bada
Current Name: Temitope Bada

Issued To: Pick up

Course Level: Medicine

Current Program
College : College of Medicine
Major : Medicine

Degrees Awarded Doctor of Medicine 14-MAY-2005
Primary Degree
Major : Medicine

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R

INSTITUTION CREDIT:

Term: Fall 2001
College of Medicine
Medicine
First-Time Professional

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
INDI	101	M	Unit I (M&C)	12.0C		0.00	
INDI	102	M	Unit II (M&C)	8.00		0.00	
INDI	106	M	Unit I (M&S)	2.00		0.00	

Term: Ehrs: 22.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00
Good Standing

Term: Spring 2002
College of Medicine
Medicine
Continuing

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
INDI	100	M	Unit II (S&F)	9.00		0.00	
INDI	103	M	Unit II (M&S)	2.00		0.00	
INDI	106	M	Unit III (M&S)	2.00		0.00	
INDI	108	M	Unit I (S&F)	18.00		0.00	
INDI	109	M	Unit III (S&F)	8.00		0.00	

Term: Ehrs: 39.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00

Term: Fall 2002
College of Medicine
Medicine
Continuing

******************** CONTINUED ON NEXT COLUMN ********************

Institution Information continued:

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
INDI	303	M	General Principles	6.00		0.00	
INDI	304	M	Hematopoetic, Lymp & Cardio	10.00		0.00	
INDI	305	M	renal/Urinary	4.00		0.00	
INDI	306	M	Comp/Alt Med; Env & Occup	2.00		0.00	

Term: Ehrs: 22.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00
Good Standing

Term: Spring 2003
College of Medicine
Medicine
Continuing

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
INDI	105	M	Prob Solving Diag Reason	2.00		0.00	
INDI	318	M	Gastrointestinal System	5.00		0.00	
INDI	319	M	Central Nervous System	5.00		0.00	
INDI	320	M	Central Nervous System	6.00		0.00	
INDI	321	M	Musculo Sys, Skin& Repro Sys	4.00		0.00	
INDI	322	M	Physical Diagnosis	8.00		0.00	
INDI	323	M	Measure Sci, Epid & Biometric	3.00		0.00	

Term: Ehrs: 33.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00
Good Standing

Term: Fall 2003
College of Medicine
Medicine
Continuing

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
CHFP	400	M	Clerkship Family Practice	4.00		0.00	
MPED	301	M	Clkshp in Pediatrics	8.00		0.00	
PSYH	340	M	Psychiatric Clerkship	6.00		0.00	

Term: Ehrs: 18.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00

Term: Spring 2004
College of Medicine
Medicine
Continuing

******************** CONTINUED ON PAGE 2 ********************

VALID ONLY WITH SILVER
HOWARD UNIVERSITY SEAL

THE FACE OF THIS TRANSCRIPT HAS A BLUE AND RED BACKGROUND ON WHITE PAPER AND CONTAINS: VOID PANTOGRAPH, CHEMICAL PROTECTION, MICROPRINT, GENUINE WATERMARK, VISIBLE FIBERS AND SILVER HOLOGRAPHIC SEAL.

HOWARD UNIVERSITY
Office of Enrollment Management
Washington, D.C.

Date Issued: 07-AUG-2012
WEB

Page: 2

Student No:

Record of: Temitope Bada
Level: Medicine

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
Institution Information continued:							
MEDI	417	M	Intro to Ethic-Jursi	2.00		0.00	
OBGY	302	M	Obstetrics & Gynecology	8.00		0.00	
SURG	302	M	Surgery 3rd Yr	8.00		0.00	
Term:			Ehrs: 18.00 GPA-Hrs: 0.00 QPts:	0.00	GPA:	0.00	
Good Standing							
Term: Summer 2004							
College of Medicine							
Medicine							
Continuing							
INDI	300	M	Rehab & Neuro Diseases	4.00		0.00	
MEDI	401	M	Medicine	12.00		0.00	
Term:			Ehrs: 16.00 GPA-Hrs: 0.00 QPts:	0.00	GPA:	0.00	
Good Standing							
Term: Fall 2004							
College of Medicine							
Medicine							
Continuing							
MEDI	424	M	Clinical Infectious Diseases	4.00		0.00	
OBGY	411	M	Maternal Fetal Medicine	4.00		0.00	
OBGY	418	M	Maternal Fetal Medicine	4.00		0.00	
SURG	402	M	Surgery 4th Yr	4.00		0.00	
Term:			Ehrs: 16.00 GPA-Hrs: 0.00 QPts:	0.00	GPA:	0.00	
Good Standing							
Term: Spring 2005							
College of Medicine							
Medicine							
Continuing							
CHFP	302	M	Senior Medical Preceptorship	4.00		0.00	
MEDI	402	M	Sr. Medicine	4.00		0.00	
RADI	210	M	Radiology	4.00		0.00	
Term:			Ehrs: 12.00 GPA-Hrs: 0.00 QPts:	0.00	GPA:	0.00	
Good Standing							

******************** CONTINUED ON NEXT COLUMN ********************

********************** TRANSCRIPT TOTALS ***********************

	Earned Hrs	GPA Hrs	Points	GPA
TOTAL INSTITUTION	196.00	0.00	0.00	0.00
TOTAL TRANSFER	0.00	0.00	0.00	0.00
OVERALL	196.00	0.00	0.00	0.00

********************** END OF TRANSCRIPT ***********************

VALID ONLY WITH SILVER
HOWARD UNIVERSITY SEAL

THE FACE OF THIS TRANSCRIPT HAS A BLUE AND RED BACKGROUND ON WHITE PAPER AND CONTAINS: VOID PANTOGRAPH, CHEMICAL PROTECTION, MICROPRINT, GENUINE WATERMARK, VISIBLE FIBERS AND SILVER HOLOGRAPHIC SEAL.

Student No:

Record of: Temitope Bada
Current Name: Temitope Bada

Issued To: Pick up

Course Level: Undergraduate

HOWARD UNIVERSITY
Office of Enrollment Management
Washington, D.C.

Date Issued: 07-AUG-2012
WEB

Degrees Awarded Bachelor of Science 13-MAY-2000
Primary Degree
Major : Biology
Secondary

INSTITUTION CREDIT:

Term: Fall 1996
College of Arts & Sciences
Undetermined
First Time in College

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
BIOL	101	M	GEN BIOLOGY I LC/LB	4.00		12.00	
CHEM	003	M	GEN CHEM LEC	4.00		12.00	
CHEM	005	M	GEN CHEM LAB	1.00		3.00	
ENGL	002	M	FRESHMAN ENGLISH	3.00		6.00	
FRSM	001	M	FRESHMAN ORIENTATION	1.00		0.00	
MATH	007	M	PRECALCULUS	4.00		12.00	
SPAN	001	M	SPANISH I	4.00		16.00	

Term: Ehrs: 21.00 GPA-Hrs: 20.00 QPts: 61.00 GPA: [illegible]

Term: Spring 1997
College of Arts & Sciences
Undetermined
Continuing

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
BIOL	102	M	GEN BIOLOGY II LC/LB	4.00		12.00	
CHEM	004	M	GEN CHEM LEC	4.00		12.00	
CHEM	006	M	GEN CHEM LAB	1.00		4.00	
ENGL	003	M	FRESHMAN ENGLISH	3.00		9.00	
HUCO	101	M	PRIN OF SPEECH	3.00		12.00	
PHED	026	M	BEGINNING TENNIS	1.00		2.00	
SPAN	002	M	SPANISH II	4.00		16.00	

Term: Ehrs: 20.00 GPA-Hrs: 20.00 QPts: 67.00 GPA: [illegible]

******************** CONTINUED ON NEXT COLUMN ********************

Institution Information continued:

Term: Summer 1997
College of Arts & Sciences
Undetermined
Continuing

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
PHED	002	M	BEGINNING SWIMMING	1.00		4.00	
PHED	011	M	WEIGHT TRAINING	1.00		4.00	
PHYS	001	M	GEN PHYS LEC-LAB-REC	5.00		15.00	
PHYS	002	M	GEN PHYS LEC-LAB-REC	5.00		15.00	

Term: Ehrs: 12.00 GPA-Hrs: 12.00 QPts: 38.00 GPA:

Term: Fall 1997
College of Arts & Sciences
Undetermined
Continuing

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
ANTH	110	M	INTRO TO CULT ANTHRO	3.00		9.00	
CHEM	141	M	ORG CHEM LEC	3.00		9.00	
ENGL	055	M	AFR-AM LIT II	3.00		6.00	
MATH	156	M	CALCULUS I	4.00		12.00	
PHED	160	M	WOMEN'S HEALTH	1.00		3.00	
SPAN	003	M	SPANISH III	3.00		12.00	

Term: Ehrs: 17.00 GPA-Hrs: 17.00 QPts: 51.00 GPA:

Term: Spring 1998
College of Arts & Sciences
Undetermined
Continuing

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
CHEM	142	M	ORGANIC CHEM LEC	3.00		6.00	
CHEM	145	M	ORG CHEM LB-LC	3.00		9.00	
HIST	101	M	WORLD GEOGRAPHY	3.00		6.00	
PHIL	051	M	PRIN OF REASONING	3.00		12.00	
SPAN	004	M	SPANISH IV	3.00		12.00	
SPAN	701	M	AF HISP LIT ENG WRTG	3.00		9.00	

Term: Ehrs: 18.00 GPA-Hrs: 18.00 QPts: 54.00 GPA:

******************** CONTINUED ON PAGE 2 ********************

VALID ONLY WITH SILVER
HOWARD UNIVERSITY SEAL

THE FACE OF THIS TRANSCRIPT HAS A BLUE AND RED BACKGROUND ON WHITE PAPER AND CONTAINS: VOID PANTOGRAPH, CHEMICAL PROTECTION, MICROPRINT, GENUINE WATERMARK, VISIBLE FIBERS AND SILVER HOLOGRAPHIC SEAL.

HOWARD UNIVERSITY
Office of Enrollment Management
Washington, D.C.

Student No:

Record of: Temitope Bada
Level: Undergraduate

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
Institution Information continued:							
Term:			Summer 1998				
College of Arts & Sciences							
Undetermined							
Continuing							
AFST	106	M	AFRICAN WORLD	3.00		12.00	
CLAS	103	M	CLASSICAL ART	3.00		9.00	
Term:			Ehrs: 6.00 GPA-Hrs: 6.00 QPts:	21.00	GPA:		
Term:			Fall 1998				
College of Arts & Sciences							
Undetermined							
Continuing							
BIOL	441	M	GEN ENDOCRINOLOGY I	0.00		0.00	
BIOL	445	M	BIOCHEM GENETI LC-LB	4.00		12.00	
POLS	011	M	STATE & LOCAL GOVT	3.00		9.00	
SPAN	050	M	ORAL EXPRESSION I	3.00		12.00	
Term:			Ehrs: 10.00 GPA-Hrs: 10.00 QPts:	33.00	GPA:		
Term:			Spring 1999				
College of Arts & Sciences							
Undetermined							
Continuing							
BIOL	200	M	GENETICS LEC-LAB	4.00		12.00	
BIOL	444	M	NEUROPHYSIO LC-LB	4.00		0.00	E
BIOL	494	M	SENIOR SEMINAR	1.00		4.00	
GERM	101	M	LITERATURE OF LOVE	3.00		9.00	
Term:			Ehrs: 12.00 GPA-Hrs: 12.00 QPts:	29.00	GPA:		
Term:			Summer 1999				
College of Arts & Sciences							
Undetermined							
Continuing							

******************** CONTINUED ON NEXT COLUMN *******************

SUBJ	NO.	C	COURSE TITLE	CRED	GRD	PTS	R
Institution Information continued:							
BIOL	220	M	General Microbiology	4.00		12.00	
Term:			Ehrs: 4.00 GPA-Hrs: 4.00 QPts:	12.00	GPA:		
Term:			Fall 1999				
College of Arts & Sciences							
Biology							
Continuing							
BIOL	340	M	Bacterial Physiology Lecture	4.00		12.00	
BIOL	390	M	Independent Investigations	3.00		12.00	
BIOL	450	M	Molecular Genetics	4.00		16.00	
Term:			Ehrs: 11.00 GPA-Hrs: 11.00 QPts:	40.00	GPA:		
Term:			Spring 2000				
College of Arts & Sciences							
Biology							
Continuing							
BIOL	444	M	Neurosphysio Lec-Lab	4.00		12.00	I
CLAS	109	M	Classical Mythology-Egypt	3.00		9.00	
Term:			Ehrs: 7.00 GPA-Hrs: 7.00 QPts:	21.00	GPA:		
Good Standing							

********************** TRANSCRIPT TOTALS ***********************

	Earned Hrs	GPA Hrs	Points	GPA
TOTAL INSTITUTION	134.00	133.00	423.00	
TOTAL TRANSFER	0.00	0.00	0.00	0.00
OVERALL	134.00	133.00	423.00	

********************** END OF TRANSCRIPT ***********************

VALID ONLY WITH SILVER
HOWARD UNIVERSITY SEAL

THE FACE OF THIS TRANSCRIPT HAS A BLUE AND RED BACKGROUND ON WHITE PAPER AND CONTAINS: VOID PANTOGRAPH, CHEMICAL PROTECTION, MICROPRINT, GENUINE WATERMARK, VISIBLE FIBERS AND SILVER HOLOGRAPHIC SEAL.

DOH-HPLA
PROCESSING CENTER
2012 AUG 13 AM 10 20

AMA Physician Profile

Name and Mailing Address:

TEMITOPE BADA MD
STE 220
1111 SPRING ST
SILVER SPRING MD 20910-4003

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: 1-301-585-0040

Birthdate:

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

HOWARD UNIV COLL OF MED, WASHINGTON DC 20059

Degree Awarded: Yes

Degree Year: 2005

©2012 by the American Medical Association

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: NEW YORK METHODIST HOSP
Sponsoring State: NEW YORK
Specialty: OBSTETRICS & GYNECOLOGY
Dates: 07/2005 - 06/2009 (VERIFIED)

Note: **If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.**

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
MARYLAND	MD	06/09/2009	09/30/2012	ACTIVE	UNLIMITED	07/17/2012

Current and/or Historical NPI Information:

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1336376623	06/15/2009	NOT RPTD	NOT RPTD	NOT RPTD	07/25/2012

ECFMG Certfication:

Applicant Number:

Note: **The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.**

©2012 by the American Medical Association

AMA Physician Profile

Federal Drug Enforcement Administration:

** Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
XXXXXX984	22N 33N 4 5	07/31/2012	07/12/2012

Address: Metropolitan Women's Group, Ste 220, 1111 Spring St, Silver Spring, MD 20910-4003

Note: **Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.**

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate Type: GENERAL

Duration	Effective	Expiration	Reverification	Occurrence	Last Reported
TIME LIMITED	01/13/2012	12/31/2012		INITIAL	07/09/2012

Note: **For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.**

***This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties. Copyright 2012 American Board of Medical Specialties. All right reserved.**

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

©2012 by the American Medical Association

AMA Physician Profile

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site (http://www.ama-assn.org/go/amaprofiles) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60654
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

©2012 by the American Medical Association

* Kimberly Campbell-Arrendell, MD * Yolande Hackney, MD * Leslie Simmons, MD * O. Temitope Bada, MD *

August 6, 2012

Health Professionals Licensing Administration

Re: Oluwafunmilola T. Bada, MD

To Whom It May Concern,

Dr. Bada is currently employed with Metropolitan Women's Group, LLC, as a full time, OB/GYN physician with an effective hire date of August 3, 2009.

Sincerely,

Cathryn T. Grayton
Practice Administrator
Metropolitan Women's Group, LLC
Direct: 301-585-8796

1111 Spring Street * Suite 220 * Silver Spring MD 20910 * 301-585-0040 * Fax 301-565-8079
7701 Greenbelt Road * Suite 503 * Greenbelt MD 20770 * 301-513-0200 * Fax 301-513-0555
www.metropolitanwomensgroup.com

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
4201 Patterson Avenue
Baltimore, MD 21215-0095
(410) 764-4777
Fax (410) 358-2252

August 21, 2012

To: Medical Board of Washington DC

The following is available under the Maryland Public Information Act, State Government Article, Section 10-617(h), regarding the following practitioner:

BADA, OLUWAFUNMILOLA T.

For the Practice of:	Physician
License Number:	D0069373
Date Issued:	June 09, 2009
Current Status:	Active
Expiration Date:	September 30, 2012
Medical School:	HOWARD UNIV COLL OF MED
Licensed By:	USMLE Steps 1, 2, and 3
Specialty:	
Charges:	
Disciplinary Actions:	NONE

No Maryland Health Claims Arbitration Office malpractice claims filed since July 1, 1986

Verification Clerk

08/21/2012

Date

This is a computer generated form which is acceptable by other states.
Licensing examination scores should be requested directly from the examining authority.

CN 104841

108
60

MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217**
Baltimore, MD 21297
410-764-4705 or 1-800-492-6836, ext 4705

REQUEST FOR VERIFICATION OF LICENSURE/JURISDICTION CLEARANCE

To request a written verification (Letter of Good Standing) of your Maryland license, complete this form and return it to the mailing address above with your fee (check or money order) payable to "Maryland Board of Physicians." The verification fee for physicians (MD/DO) is $50; Allied Health is $25 (CNMT, PA-C, RPSGT, RT(T), RT(R), RCP(CRT/RRT)). No fee required for Unlicensed Medical Practitioner (UMP) verification request.

Licensee Information:

Name: BADA (Last Name) OLUWAFUNMILOLA (First Name) TEMITOPE (Middle Name)

License #: D69373 Social Sec#. ______ Telephone # ______

Licensee's Address: ______

City: ______ State: ______ Zip Code: ______

I hereby authorize the Maryland Board of Physicians to release any information, favorable or otherwise against my ~~license to the~~ state licensing board/entity or person listed below.

Signature: Tope Bada Date: AUG 7 2012

****

Mailing Information:

Please provide the name and full address where the completed verification will be mailed. Verification letters are sent directly to another licensing board from our office unless you specify otherwise.

Name/State Board Name: HEALTH PROFESSIONAL LICENSING ADMINISTRATION DEPT OF HEALTH

Street/Mailing Address: 899 NORTH CAPITOL ST, NE, FIRST FLOOR

City: WASHINGTON State: DC Zip Code: 20002

Verifications are sent by first-class mail. If you want the verification delivered by courier, please attach a self-addressed/prepaid mailing envelope or packing slip for Fedex/UPS.

*** This address is our bank processing center. Your verification request will be processed after the check/money order has been deposited by the bank. Sending this request to a different board address will delay processing of your verification.*

The Federation of State Medical Boards of the United States, Inc

Federation Credentials Verification Service
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039
Telephone: (817) 868-5000
Fax: (817) 868-5099

DOH-HPLA
PROCESSING CENTER
2012 JUL 6 AM 10 17

Physician Information Profile

This report is compiled exclusively for:

Name: **Oluwafunmilola Temitope Bada**
SSN:
DOB:
Packet ID: **102928**
Recipient: **District of Columbia Board of Medicine**

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.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

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

© 1996 Federation of State Medical Boards
Rev. 4/26/2011

Table of Contents

I. FCVS / FSMB Reports

A. Physician Information Report
B. Credentials Analysis Report
C. Board Action Data Bank Search Results
D. ABMS Specialty Certification(s)

II. Identity

A. Affidavit and Release
B. Certified Birth Certificate or Photocopy of Original Passport

III. Medical Education

A. Verification of Medical Education Form(s)
B. Official Medical Education Transcripts(s)
C. Certified Photocopy of Medical School Diploma
D. Verification of Fifth Pathway Form(s)
E. Photocopy of Fifth Pathway Certificate of Completion
F. Confirmation of ECFMG Certification
G. Photocopy of ECFMG Certificate

IV. Graduate Medical Education

A. Verification of Graduate Medical Education Form(s)

V. Examination History / Score Transcripts **(State Licensing Authorities Only)**

A. USMLE Transcript
B. FLEX Transcript
C. NBME Record of Scores
D. NBME Endorsement of Certification
E. NBOME Transcript
F. LMCC Transcript
G. State Board Exam Transcript

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Oluwafunmilola Temitope Bada**	
Other Name Used:	**Temitope Bada**	
Gender:	**Female**	
Date of Birth:		
Place of Birth:		
SSN:		
Current Address:		
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**202-277-2631**
	Fax:	**N/A**
	Home:	
	Other:	**N/A**
Physical Description:	Height:	
	Weight:	
	Eye Color:	**Brown**
	Hair Color:	**Black**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

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

Institution:	**Howard University, Washington, DC 20059**
Dates of Attendance:	**08/1996 - 05/2000**
Degree Conferred/Issued:	**Bachelor of Science**

Medical Education:

Medical School:	**Howard University College of Medicine** **Transcript Division** **2400 6th Street NW Room 105** **Washington, DC 20059**
Dates of Attendance:	**08/27/2001 - 05/14/2005**
Date Degree Conferred/Issued:	**05/14/2005**
Degree Conferred/Issued:	**Doctor of Medicine**

Unusual Circumstance:	**None**

Graduate Medical Education:

Institution:	**New York Methodist Hospital** **Department of Obstetrics/Gynecology** **506 Sixth Street** **Brooklyn, NY 11215-9008**
Training Level:	**1-3**
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2005 - 06/30/2008**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**4**
Program Type:	**Chief Resident**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2008 - 06/30/2009**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**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:	Oluwafunmilola Temitope Bada
DOB:	
SSN:	
Packet ID:	102928
Request ID:	25307836

OMISSIONS

Omission 1:

Section of Profile: **Medical Education**

Omission: Howard Univ Col Med did not certify the original language medical school diploma; however, did provide a certified English diploma translation.

Follow-Up: FCVS has contacted the institution and requested a seal or notarization be affixed to the diploma. Once received, FCVS will forward the certified diploma to you upon request.

DISCREPANCIES

Discrepancy 1:

Section of Profile: **Medical Education**

Discrepancy: The applicant reports the degree/diploma was issued/conferred/awarded by Howard Univ Col Med on 05/13/2005. The institution reports 05/14/2005. OK

Follow-Up: Due to the multiple definitions of "graduation date" by various international medical schools, FCVS has defined "graduation date" to be the date the diploma was issued to the applicant by the medical school.

MISCELLANEOUS INFORMATION

There are none identified.

End of report for Oluwafunmilola Temitope Bada

Packet Id: 102928 Request Id: 25307836 Report Created By: DSAWAF

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

July 02, 2012

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

Re: Board Action Query Dated: July 02, 2012
Your Reference Number:
FSMB Batch Number: BQ2102982

The following is a final report of the search results from the Board Action Data Bank as of July 02, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of July 02, 2012

Item	Name	DOB	School	Yr/Grad	Request ID
10	Bada, Oluwafumilola Temitope		009030		25447783

LICENSE HISTORY
State Board
No License Information Available

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

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 7/2/2012

State Queried For:	District of Columbia Board of Medicine
Physician Name:	Oluwafunmilola Temitope Bada
Date of Birth:	
Year of Graduation:	(Doctor of Medicine)
Social Security Number:	
ABMSU ID:	984503

Certification:

Board:	Obstetrics and Gynecology
Specialty:	Obstetrics and Gynecology
Status:	ACTIVE
Initial Certification:	01/13/2012

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

Section II

Identity

Federation of
STATE
MEDICAL
BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, 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 waive confidentiality, 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 (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

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

BADA
Applicant's Printed Last Name

OLUWAFUNMILOLA T.
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

3/23/09
Date of Signature

Date of Birth

Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

GAIL FAIVUSH
Notery Public, State of New York
No. 01FA5028551
Qualified in Kings County
Commission Expires April. 18, 2010

State of New York County of Kings

SUBSCRIBED AND SWORN TO before me this 23 day of March, 20 09

My commission expires: April 18, 2010

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: [signature]

I certify that on the date set forth above 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.

Section III

Medical Education

F[redacted]RATION CREDENTIALS VERIFICATION SERVI[redacted]CVS)

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: Howard University College of Medicine

Complete Address:

Street Address: 520 W Street, NW, Rm. 527

City: Washington **State:** DC **ZIP Code (Postal Code):** 20059

If name of institution was different when this individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: 3 - 4 years

Credential/degree presented by the applicant for admission to your medical school: Bachelor of Science

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

attended our medical school for total of 144 weeks of medical education on the following dates (mm/dd/yy):

From 8 / 27 / 2001 (Month / Date / Year) **To** 5 / 14 / 2005 (Month / Date / Year)

This individual (check one):

Was awarded the degree of Doctor of Medicine on 5 / 14 / 2005 (Month / Date / Year)

Was NOT awarded a degree because:
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Sheik N. Hassan, M.D., FCCP (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.

Signature: [signature]

Title: Associate Dean for Academic Affairs

Date of Signature: April 15, 2009

Phone: (202) 806-9494 **Fax:** (202) 806-7934

Email: shassan@howard.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 for behavioral reasons 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 incompetence, 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.

Medical Education

School 009030 - Howard University College of Medicine

PROVIDED BY APPLICANT

Dates 08/2001 to 05/2005

Clinical Training *No information reported.*

Grad Date 05/13/2005

Degree MD

Completed clinical clerkship in a country other than where my medical school was located: N

Unusual Circumstances:

Interruptions: N

Probation: N

Disciplined: N

Negative Reports: N

Limitations: N

Attended a Fifth Pathway Program: N

HOWARD UNIVERSITY

Grading System*

Grade	Interpretation	Quality Points per Semester Hour of Credit
A	Excellent	4
B	Good	3
C	Fair	2
D	Poor	1
F	Failure	0
P	Pass, on Pass/Fail Course	-
H	Honors	-
S	Satisfactory	-
U	Unsatisfactory	-
W	Withdrew	-
AD	Audit	-
UW	Unofficial Withdrawal	-

*Grading System is applicable to undergraduate programs. Please refer to the current graduate and professional schools' bulletins for information about the grading systems used in those schools.

In Progress

The final grade has not been submitted by the instructor.

Academic Status

There are three categories of academic status for undergraduate students: Good Standing, Probation, and Suspension.

Honors

Academic honors are awarded to graduating seniors who have earned cumulative grade point averages as follows:

3.20 - 3.49	Cum Laude
3.50 - 3.79	Magna Cum Laude
3.80 - 4.00	Summa Cum Laude

Release of Student Information

Transcripts are provided at the request of the student in accordance with Public Law 93-380 (Family Educational Rights and Privacy Act of 1974). This record is released with the understanding that the recipient will not permit any other party to have access to it without written consent of the student concerned. See paragraph 99.29 of the Family Educational Rights and Privacy Act of 1974.

Repetition of Courses

An undergraduate student may repeat only once a course in which he/she has received a grade of *D* or *F*. The lower grade will not be counted in the computation of the cumulative GPA.

Exceptions to repeating a course more than once will be made only if it is a major or minor requirement for which the minimum grade of C is required, or if a student is ineligible to advance to the next level without a passing grade. All subsequent repeats, after the first one, will be counted in the computation of the GPA. The failing or previous grade received in repeated courses is not expunged from the academic record.

Students are not eligible to graduate with honors if they have repeated a course(s); they have not carried at least 12 credits for each semester enrolled, with the exception of the last semester in residence; and they have not completed the last half of the work required for their degree in residence at Howard.

RECEIVED APR 2 9 2004

Key to Abbreviations

HRS	Hours Earned
PTS	Quality Points (value assigned for letter grade)
GPA	Grade Point Average
E	Repeated Course (grade not calculated in GPA)
I	Repeat Course (grade calculated in GPA)
R	Courses considered under course repetition policy
GRD	Grade
SUBJ	Subject
No.	Course Number
C	Campus

Universitas Howardiana Washingtonii
in Regione Columbiana sita

omnibus ad quos hae litterae pervenerint salutem.

Praeses Curatoresque Universitatis Howardianae praeceptoribus academicis nominantibus ac probantibus **Temitope Bada** ad gradum *Medicinae Doctoris* admiserunt eique dederunt et concesserunt omnia insignia et iura quae ad hunc gradum pertinent. In cuius rei testimonium Praeses et Ordinis Curatorum Scriba et Decanus auctoritate rite commissa die XIV mensis Maii anno Salutis Humanae MMV Universitatisque Howardianae CXXXVIII litteris hisce Universitatis sigillo munitis nomina subscripserunt.

Decanus

Scriba

Praeses

HOWARD
UNIVERSITY

College of Medicine
Office of the Dean

TRANSLATION

HOWARD UNIVERSITY DIPLOMA

To all to whom these letters come, greetings:

The President and Trustees of Howard University upon the recommendation of the faculties have conferred upon ***Temitope Bada*** the degree Doctor of Medicine and have granted her the rights and privileges pertaining thereto. In testimony thereof the President, the Secretary of the Board of Trustees, and the Dean by virtue of the authority invested in them have affixed their signatures hereto, together with the seal of the University on the fourteenth day of May in the year two thousand and five and in the one hundred and thirty-seventh year of the University.

Secretary Seal

President Dean

This is a true and correct translation of the original diploma issued to

Dr. Temitope Bada.

Official Name: Sheik N. Hassan, M.D., FCCP

Title: Associate Dean for Academic Affairs

SEAL VERIFIED

SNH:dmw

520 W Street, NW
Washington, DC 20059

Telephone 202 806 6270
Facsimile 202 806 7934
www.howard.edu

Section IV

Graduate Medical Education Training

Verification of Graduate Medical Education

Institution: New York Methodist Hospital

Specialty: Obstetrics/Gynecology

Address: Brooklyn, NY 11215-9008

Attention: **Program Director**

Affiliated University: ____

Verification For:

Name: **Bada, Oluwfunmilola Temitope**

DOB: ____

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

Program Participation:

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

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

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

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

Specialty/Subspecialty: OB/GYN
From: 07/01/2005 To: 6/30/2008
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: PGY4 (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☒ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: OB/GYN
From: 7/1/2008 To: 6/30/2009
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

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

Specialty/Subspecialty: ____
From: / / To: / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

____

____

Certification:

ELECTRONIC SEAL VERIFIED

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

Name: Sanford Lederman, MD

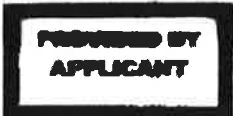
Signature: Sanford Lederman, MD

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

Date of Signature: 6/22/2012

Tel: 718-780-3272 Fax: 718-780-3079 E-Mail: sal9047@nyp.org

Federation of STATE MEDICAL BOARDS



Full Name: Oluwafunmiloa Temitope Bada

Packet ID: 102928

20. Graduate Medical Education

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

IMPORTANT:

Report incomplete training levels (years) separate from those that were successfully completed.

If your training level (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.

If a break of six (6) months or more occurred between any of your graduate medical education activities, please provide a written explanation outlining your activities during this period on the "Explanation of Other Activities" form.

New York Methodist Hospital
Complete name of hospital where training was conducted (Do not abbreviate).

____
Complete name of affiliated university or college (Do not abbreviate).

506 6th St.
Address line 1

____
Address line 2

Brooklyn
City

NY
State/Province

USA
Country

11215- ____
ZIP/Postal Code

Training Level (e.g.: 1, 2, 3, etc.): 1-3

- ☐ Internship
- ☒ Residency
- ☒ Chief Residency
- ☐ Fellowship
- ☐ Research

OB-GYN
Specialty/Subspecialty

From: 07/2005 To: 06/2009

Successfully Completed? ☒ Yes ☐ No ☐ In Progress

Training Level (e.g.: 1, 2, 3, etc.): ____

- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

____
Specialty/Subspecialty

From: ___/___ To: ___/___

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

Training Level (e.g.: 1, 2, 3, etc.): ____

- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

____
Specialty/Subspecialty

From: ___/___ To: ___/___

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

Training Level (e.g.: 1, 2, 3, etc.): ____

- ☐ Internship
- ☐ Residency
- ☐ Chief Residency
- ☐ Fellowship
- ☐ Research

____
Specialty/Subspecialty

From: ___/___ To: ___/___

Successfully Completed? ☐ Yes ☐ No ☐ In Progress

Unusual Circumstances (check yes or no):

Question	Yes	No
Did you ever take a leave(s) of absence or break(s) from your medical education?	☐	☒
Were you ever placed on probation?	☐	☒
Were you ever disciplined or placed under investigation?	☐	☒
Were any negative reports for behavioral reasons ever filed against you?	☐	☒
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	☐	☒

Please explain any "YES" response from above:

____

Signature: *Oluwafunmilola T. Bada* Date: 06/25/2012

By typing my name above, I certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set

Section V

Examination History/Score Transcripts

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4041

Date : 06/08/2012

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Euless, TX 76039

Packet ID: 102928

Examinee ID#:
Date of Birth:

Examinee: Bada, Oluwafunmilola Temitope
Alt Name(s): Bada, Temitope

Results for 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. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
06/16/2003						

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
09/24/2004						

Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
05/23/2007						
04/19/2005						

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
MARYLAND	12/04/2007						

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

UNOFFICIAL COPY · NOT AN ORIGINAL DOCUMENT

29