#137847

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://.med.ohio.gov/

Ohio Addendum to Application

Ohio Training Program

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

Name of Hospital/Training Program _____ City _____ Start Date: ____/____ month/year

Specialty Boards

Name of Specialty Board (If none, enter "N/A")	Year Certified	Country
Family Medicine	07/2012	USA

TOEFL IBT

(International Medical School Graduates only)

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

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL IBT, regardless of citizenship or country of birth. Prior to July 2006 the Test of Spoken English was required with a minimum score of 40 (between 7/95-7/06) or 230 (prior to 7/95). The following are the only exceptions permitted under Ohio law:

	YES	NO
Have you completed two years of undergraduate college work in the United States?	☐	☐
During the five years immediately preceding the date of your application, have you: (Please note you must be able to answer "YES" to both parts of this question) Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States? **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?	☐	☐
Have you completed a Fifth Pathway program?	☐	☐
Have you passed the Clinical Skills Assessment examination given by ECFMG on or after July 1, 1998?	☐	☐

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

Applicant Name: Sarah Pickle, MD Date: 01/15/2015

Ohio Addendum to Application

Preliminary Education Form

TO BE COMPLETED BY ALL APPLICANTS

apr mtgm 2/6/15

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	Pickle	Sarah	Rachel	

High School or Equivalent

School Name: Marquette High School
City: Chesterfield
State: Missouri
Country: USA

Dates Attended — From: MO/YR 08/97 To: MO/YR 06/01

Undergraduate College or Equivalent

School Name: Miami University
City: Oxford
State: OH
Country: USA

Dates Attended — From: MO/YR 08/01 To: MO/YR 06/05
Degree Received: B.A.

School Name:
City:
State:
Country:

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

Medical or Osteopathic School of Graduation

School Name: University of Cincinnati College of Medicine
City: Cincinnati
State: OH
Country: USA

Dates Attended — From: MO/YR 08/05 To: MO/YR 06/09
Degree Received: Medical degree (MD)

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

MEDICAL BOARD
FEB 6 2015

NO: 130565 DATE ISSUED: FEB 17 2015

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

Applicant Name: Sarah Pickle, MD Date: 01/15/2015

Ohio Addendum to Application
Additional Information
Medicine or Osteopathic Medicine

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

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

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

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☒
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☒
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☒
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. Photocopies will not be accepted.	☐	☒
16	Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. Photocopies will not be accepted.	☐	☒
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☒
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☒
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☒
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☒

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

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

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

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

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

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

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **You may answer "NO" to this question if** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.	☐	☒
a)	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?	☐	☒ not applicable

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

b)	Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☒ not applicable

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

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☒
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	☐	☒ not applicable

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

	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☒ not applicable

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

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

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

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

Employer Recommendation Form

URGENT LICENSURE PENDING

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

Dr. Sarah R. Pickle
(PLEASE PROVIDE THE FIRST AND LAST NAME OF THE APPLICANT)

is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above within two (2) weeks. The form may also be faxed to the Board at (614) 644-1464. Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: faculty, dept of Family Medicine

Dates of employment: July 2012 - present (Jan. 2015)

(1) How long have you known him/her? 2.5 years

(2) What is/was your supervisory capacity? Director of Women's Health Division.

(3) At what hospital? Rutgers- Robert Wood Johnson Medical School

(4) How would you rate his/her medical knowledge and techniques? OUTSTANDING

(5) In your opinion is he/she a person of good moral and ethical character? Yes, ABSOLUTELY

(6) Does he/she work well with peers and medical staff? She is an incredible team player

(7) Does he/she relate well to patients? Sarah has a wonderful rapport with her patients

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

(9) Would you recommend him/her for licensure? Yes, WITHOUT RESERVATION

Additional comments, please: (f needed, an extra sheet of paper may be used)
Dr Sarah Pickle is an outstanding Family Physician educator and women's health advocate

Sincerely,
Nicole Weaver
Chief, Licensure

Signature of Physician 2/10/2015

Jeffrey P. Levine
Name of Physician (please type or print clearly)

Professor & Director of Women's Health Programs
Position

732-235-7672
Telephone number (include area code)

732-235-6309
FAX number (include area code)

MEDICAL BOARD
FEB 6 2015

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127 614-466-9257

MEDICAL BOARD

FEB 6 2015

Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

I, Jeffrey Levine, currently hold an active license to practice as a physician in the state of
(Recommending physician, print name legibly)
New Jersey, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," and provide this recommendation form related to the request for professional licensure by Sarah R. Pickle.
(Applicant, print name legibly)

Further, the photograph affixed hereto is a genuine likeness of the applicant, who has been personally known to me for 3 years/months.

1. How do you know this applicant? I was her Fellowship Director 2012-2013, and have been her Faculty Mentor 2013 - Present
2. How would you describe the applicant's medical knowledge? OUTSTANDING - SARAH IS ONE OF THE BRIGHTEST and PROGNOSTIC PHYSICIANS I have ever had the pleasure of working with.
3. How would you describe the applicant's clinical technique? EXCELLENT CLINICAL SKILLS; including the management of complex patients and performing procedures
4. How would you characterize the applicant's relationship with patients? Sarah has a wonderful bedside manner, and develops & sustains A GREAT RAPPORT WITH her patients
5. How would you describe the applicant's ability to work with peers and clinical staff? Sarah is an incredible team player and Group Leader. She is always proactive with helping others & problem solving

6. Does the applicant possess good moral character? (If no, explain)	☒ Yes	☐ No
7. Do you recommend this applicant for the professional license being sought? (If no, explain)	☒ Yes	☐ No
8. Are you aware of any other information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain)	☐ Yes	☒ No
9. Have you attached additional correspondence or information to this form?	☐ Yes	☒ No

S Pickle
Signature of Applicant
Date Photo Taken: 01 / 2015
Month Year

DEBORAH MARIE BROOKS
Notary Public
State of New Jersey
My Commission Expires Aug 11, 2019

Jeffrey P. L MD, PhD
Signature of Recommending Physician (Name stamps not accepted)

1 Robert Wood Johnson Place MEB 262 New Brunswick NJ, 08901
Address (include house number and street, city, state and zip code)

State of Licensure and License Number NJ 58877

Subscribed and sworn to before me this 14 day of January, 2015.

Notary Public Signature

8/11/2015
Date Commission Expires

NOTARY SEAL

5M 4/12

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127 614-466-9257

Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

MEDICAL BOARD
FEB 6 2015

I, Justine Wu, currently hold an active license to practice as a physician in the state of
(Recommending physician, print name legibly)
New Jersey, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," and provide this recommendation form related to the request for professional licensure by
Sarah R. Pickle.
(Applicant, print name legibly)

Further, the photograph affixed hereto is a genuine likeness of the applicant, who has been personally known to me for 2.5 years years/months.

1. How do you know this applicant? I was one of Dr. Pickle's fellowship mentors in 2012-13. After fellowship, Dr. Pickle joined faculty and I have worked with her as a colleague since then.
2. How would you describe the applicant's medical knowledge? Superior to her peers, both in breadth and depth. Accesses appropriate evidence based resources and develops individualized management plans.
3. How would you describe the applicant's clinical technique? Superior to her peers.
4. How would you characterize the applicant's relationship with patients? Superior, one of her clinical strengths. Would send my family members to her.
5. How would you describe the applicant's ability to work with peers and clinical staff? Superior to her peers. Facilitates teamwork through trusting & respectful relationships.
6. Does the applicant possess good moral character? (If no, explain) ☒ Yes ☐ No
7. Do you recommend this applicant for the professional license being sought? (If no, explain) ☒ Yes ☐ No
8. Are you aware of any other information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐ Yes ☒ No
9. Have you attached additional correspondence or information to this form? ☐ Yes ☒ No

Signature of Applicant
Date Photo Taken: 01 / 2015
Month Year

DEBORAH MARIE BROOKS
Notary Public
State of New Jersey
My Commission Expires Aug 11, 2019

Signature of Recommending Physician (Name stamps not accepted)

1 Robert Wood Johnson Place MEB 272 New Brunswick NJ 08901
Address (include house number and street, city, state and zip code)

State of Licensure and License Number

Subscribed and sworn to before me this 15 day of January, 2015.

Notary Public Signature

8/11/2019
Date Commission Expires

NOTARY SEAL

Eff 1/12

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this to the state board you are applying to for licensure, NOT to FCVS/FSMB.

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to the board you are applying to for licensure. See http://www.fsmb.org/policy/contacts for a directory of state medical boards.

DO NOT SEND THIS FORM TO FCVS/FSMB. Doing so will delay your licensure process.

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

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

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

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

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

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

Sarah Pickle
Applicant's signature (must be signed in the presence of a notary)

Pickle
Applicant's printed last name

MEDICAL BOARD
FEB 6 2015

Sarah R.
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

1/14/2015
Date of signature (must correspond to date of notarization)

-fold up- -fold up-

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of New Jersey, County of Middlesex

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 14th day of Jan, 20 15.

Notary Public Signature:

DEBRA M PANARISI
NOTARY PUBLIC
STATE OF NEW JERSEY
MY COMMISSION EXPIRES SEPT. 8, 2015
I.D. # 2077046

My Notary Commission Expires:

(NOTARY PUBLIC SEAL)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

January 22, 2015

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	SARAH RACHEL PICKLE
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD444299
ORIGINAL LICENSURE DATE:	10/04/2011
EXPIRATION DATE:	12/31/2014
STATUS:	Inactive

The license is in good standing and the records indicate no derogatory information.

SEAL

Acting Commissioner
Bureau of Professional and Occupational Affairs

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Licensure Verification (UA Form #1)

Applicant: Complete this form as instructed in the left sidebar.
Licensing Board: Complete this form and send it to the board listed in Section 1.

Applicant:

Send this form and any applicable fee to each state board you have held a full, temporary, training, or limited license with.

Licensure Verification information (including fees) is available at http://www.fsmb.org/licensure/uniform-application/.

Copy this form for multiple licenses.

Use the medical board directory located at http://www.fsmb.org/policy/contacts to ensure you list the correct name/address.

Section 1: Applicant Information

Last name: Pickle Suffix: _____

First name: Sarah

Middle name: Rachel

Date of birth: 08/30/1982 Social Security number*: REDACTED

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Authorization: I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of Pennsylvania to provide any and all information pertaining to license number MD444299 to the following Board:

Board name: State Medical Board of Ohio

Mailing address: 30 E. Broad St. 3rd Floor

City/State/Zip: Columbus, OH 45215-6127

Applicant signature: Sarah Pickle **Date:** 1/15/2015

Licensing Board:

Please complete Section 2 of this form.

Send this form to the state board listed in Section 1.

Alternatively, provide electronic verification of licensure to the state board listed in Section 1.

DO NOT SEND THIS FORM OR ANY VERIFICATIONS TO FCVS/FSMB.

Section 2: Licensure Verification

JAN 20 2015

Name of Licensee: _____ (Last / First / Middle / Suffix)

Issuing State Board: _____ License type: _____

License number: _____ Issue date: _____ Expiration date: _____

Is this license current? ☐ Yes ☐ No If not current, please explain: _____

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? ☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state?

☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

MEDICAL BOARD

JAN 27 2015

AFFIX BOARD SEAL HERE

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

Signature: _____

Print name: _____

Title: _____

Date: _____

Email: _____

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183, Trenton, NJ 08625-0183

JOHN J. HOFFMAN
Acting Attorney General

STEVE C. LEE
Acting Director

For overnight deliveries:
140 East Front St.
PO Box 183 , 3rd Floor
Trenton, NJ 08608
(609) 826-7100
(609) 826-7101 FAX

January 23, 2015

Ohio Medical Board
30 E. Broad St. 3rd Floor
Columbus , OH 43215-6127

To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by SARAH R PICKLE to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that SARAH R PICKLE was issued a New Jersey license 25MA09105400 on or about 05/11/2012 and is currently Active with an expiration date of 06/30/2015. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,

BOARD OF MEDICAL EXAMINERS

William V. Roeder
Executive Director

WVR/dd/mac

Uniform Application for Physician Licensure

UA Username picklesr **Date Submitted** 1/14/2015
FCVS Status Applicant has an FCVS Packet

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

1. Full Name (use no initials)

Last Name Pickle
First Name Sarah
Middle Name
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

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

2. Address/Phone

Business
[X] **Public Access** **Street** 317 George Street
[ ] **Mailing**
City New Brunswick **State/Province** NJ **Zip Code** 08901
Country USA
Telephone (732) 235-8993
Fax
Email picklesr@rutgers.edu
Alternate Phone

Home
[ ] **Public Access** **Street** 404 CYPRESS LN
[X] **Mailing**
City EAST BRUNSWICK **State/Province** NJ **Zip Code** 08816-5249
Country USA
Telephone (314) 302-7887
Fax
Email pickle.sarah@gmail.com
Alternate Phone

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

3. Identification

08/30/1982	Saint Louis	Missouri	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	REDACT	1043453194	Are you a U.S. Citizen?	[X] Yes [ ] No
Gender	Social Security Number	NPI		

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

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

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

4. Medical School

1

School Name University of Cincinnati College of Medicine
Address PO Box 670555
City Cincinnati
State/Province OH
ZIP Code 45267-0555
Country USA
Attendance Dates **From (mm/yyyy)** 08/2005 **To (mm/yyyy)** 06/2009
Graduation Date 6/13/2009
Degree MD

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

5. Fifth Pathway (if applicable)

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

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

6. Postgraduate Training

1 **Hospital Name** Thomas Jefferson University Hospital
Hospital Address 111 S. 11th Street

City Philadelphia
State/Province Pennsylvania
ZIP Code 19107
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Family Medicine

From: 06 /2009 **To:** 06 /2012 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

2 **Hospital Name** UMDNJ Robert Wood Johnson Medical School
Hospital Address 1 Robert Wood Johnson Place

City New Brunswick
State/Province New Jersey
ZIP Code 08901
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☐ **Residency** ☒ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Women's Health Fellowship

From: 07 /2012 **To:** 07 /2013 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

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

7. Examination History

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

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/2007	[X] P	[ ] F	1
USMLE Step 2		08/2008	[X] P	[ ] F	1
USMLE Step2 CS		12/2008	[X] P	[ ] F	1
USMLE Step 3		06/2010	[X] P	[ ] F	1

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

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

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

9. State Licensure

1	**State/Province**	NJ	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	25MA09105400	**Status**	Active	**Issue Date**	5/1/2012	
2	**State/Province**	PA	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**		
	License Number	MD444299	**Status**	Inactive	**Issue Date**	10/1/2011	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 06 Year: 2009 To: Month: 06 Year: 2012 In Progress ☐	**Practice/Employment Name** Thomas Jefferson University Hospital Family Medicine Residency (or list non-working time as indicated above) **Practice/Employment Address** 111 S. 11th Street **City** Philadelphia **State/Province** Pennsylvania **ZIP Code** 19107 **Country** USA **Position and Department** Resident Physician-Family Medicine **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
2 From: Month: 07 Year: 2012 To: Month: 07 Year: 2013 In Progress ☐	**Practice/Employment Name** UMDNJ Robert Wood Johnson Medical School Women's Health Fellowship (or list non-working time as indicated above) **Practice/Employment Address** 1 Robert Wood Johnson Place MEB 262 **City** New Brunswick **State/Province** New Jersey **ZIP Code** 08901 **Country** USA **Position and Department** Women's Health Fellowship-Family Medicine **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
3 From: Month: 07 Year: 2013 To: Month: Year: In Progress ☒	**Practice/Employment Name** Assitant Professor Rutgers Robert Wood Johnson Medical School (or list non-working time as indicated above) **Practice/Employment Address** 1 Robert Wood Johnson PLace **City** New Brunswick **State/Province** New Jersey **ZIP Code** 08901 **Country** USA **Position and Department** Assistant Professor, Faculty-Department of Family Medicine **Percent Clinical:** 70% **Percent Administrative:** 30% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

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

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

Current status of claim:

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

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

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for

Name: **Sarah Pickle**

Social Security Number: REDACTED

Date of Birth: **August 30, 1982**

FID#: **215436841**

Recipient: **OH - State Medical Board of Ohio**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

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

Medical Professional Name: **Sarah Pickle**
Date of Birth: **August 30, 1982**
Social Security Number: REDACTED
FID: **215436841**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate OR Copy w/ Cert. of Identification

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

University of Cincinnati College of Medicine
1. Medical Education Form and Translation
2. Medical Education Dean's Letter
3. Medical Education Transcript and Translation
4. Medical Education Diploma and Translation

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Thomas Jefferson University Hospital
1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

A. FSMB Exam Transcript

End of report for: Sarah Pickle

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

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Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name:	**Sarah Pickle**
	Documentation: Certified Birth Certificate OR Copy w/ Cert. of Identification
Variation of Name:	**Sarah Rachel Pickle**
	Documentation: Certified Birth Certificate OR Copy w/ Cert. of Identification
Gender:	Female
Date of Birth:	August 30, 1982
Place of Birth:	St. Louis, MO, UNITED STATES
Social Security Number:	REDACTED
FID:	215436841
Physical Description:	Height: 5 ft. 5 in.
	Weight: 130 lbs.
	Eye Color: Green
	Hair Color: Brown

Contact Information

Mailing Address:	404 CYPRESS LN EAST BRUNSWICK, NJ 08816-5249 UNITED STATES
Permanent Address:	404 CYPRESS LN EAST BRUNSWICK, NJ 08816-5249 UNITED STATES
Telephone Numbers:	Primary: (314) 302-7887
	Secondary: N/A
	Fax: N/A
	Other: N/A

Pre-medical Education

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

Institution: **Miami University**
Address: Oxford, OH 45056-3433
UNITED STATES
Dates of Attendance: 08/--/2001 To 05/--/2005
Degree Conferred/Issued: Bachelor of Arts

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **University of Cincinnati College of Medicine**
Address: CARE/Crawley Building Ste E-870
Cincinnati, OH 45267
UNITED STATES

Dates of Attendance: 08/15/2005 to 05/22/2009
Date Certificate Issued: 06/13/2009
Degree Conferred/Issued: Doctor of Medicine

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

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **Thomas Jefferson University Hospital**
Address: 1015 Walnut Street, Suite 401

Philadelphia, PA 19107
UNITED STATES

Training Level: 1
Program Type: Internship/Residency
Specialty: Family Medicine
Dates of Attendance: 06/20/2009 To 06/30/2010
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2 - 3
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/2010 To 06/30/2012
Completed Successfully: Yes
Accreditation: ACGME

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

Licensure Examinations

FSMB Transcript USMLE Step 1	Date: 06/2007	Passed the Exam
FSMB Transcript USMLE Step 2 CK	Date: 08/2008	Passed the Exam
FSMB Transcript USMLE Step 2 CS	Date: 12/2008	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 06/2010	Passed the Exam

ABMS Verification

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

Board Action

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

End of report for: Sarah Pickle FID: 215436841

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

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

Medical Professional Identification

Medical Professional Name:	**Sarah Pickle**
Date of Birth:	**August 30, 1982**
Social Security Number:	REDACTED
FID:	**215436841**

Omissions

There are no omissions identified.

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Discrepancies

There are no discrepancies identified.

Miscellaneous Information

Miscellaneous 1:

Section of Profile:	**Post Graduate Training**
Miscellaneous:	**Verification of the Graduate Medical Education at UMDNJ Robert Wood Johnson Medical School dated 07/--/2012 to 07/--/2013 reported by the applicant in the Chronology of Activities is not included in the Medical Professional Information Profile.**
Action Taken:	**FCVS does not obtain verification of non-accredited Fellowship/Research programs.**

End of report for: Sarah Pickle

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

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

Medical Professional Name: **Sarah Pickle**
Date of Birth: **August 30, 1982**
Social Security Number: REDACTE
FID#: **215436841**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
08/2005	06/2009	Medical Education Record	University of Cincinnati College of Medicine,CARE/Crawley Building Ste E-870 Cincinnati, OH 45267 UNITED STATES		
06/2009	06/2012	GME Record	Thomas Jefferson University Hospital,1015 Walnut Street, Suite 401 Philadelphia, PA 19107 UNITED STATES		
07/2012	07/2013	GME Record	UMDNJ Robert Wood Johnson Medical School,1 Robert Wood Johnson Place New Brunswick, NJ 08901 UNITED STATES		

End of report for: Sarah Pickle

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Section II

FSMB and Other Reports

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PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:4/28/2015

PRACTITIONER INFORMATION

Name:	Sarah Rachel Pickle
DOB:	8/30/1982
Medical School:	University of Cincinnati College of Medicine Cincinnati, Ohio, UNITED STATES
Year of Grad:	2009
Degree Type:	MD
NPI:	1043453194

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
DELAWARE	C7-0004341	6/18/2009	3/31/2011	4/24/2015
NEW JERSEY	25MA09105400	5/11/2012	6/30/2015	4/3/2015
PENNSYLVANIA	MD444299	10/4/2011	12/31/2014	9/9/2013

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As of:	**04/28/2015**
Medical Professional Name:	**Sarah Rachel Pickle**
Date of Birth:	**8/30/1982**
Year of Graduation:	**2009 (Doctor of Medicine)**
ABMSUID#:	**994840**

Certification

Certification:

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

End of report for Sarah Rachel Pickle

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

Section III

Identity

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

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

I acknowledge that I have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

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

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

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

EVRIM CICEK
Notary Public
of New Jersey
Commission Expires Jan. 04, 2020

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

Pickle
Applicant's **Printed** Last Name

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

02/06/2015
Date of Signature (**must** correspond to date of notarization)

State of New Jersey, County of Middlesex,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 6th day of February 2015.

Notary Public Signature: _____

My Notary Commission Expires: Jan. 04, 2020

Please complete and mail this original document to the Federation of State Medical Boards at:

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

330952

215436841

RECEIVED
JAN 20 2015

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Pickle (Last) Sarah (First) Rachel (Middle)

FCVS ID Number: 330952

Notary – Please complete the section below:

State of New Jersey County of Middlesex

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 14, of (Month) January, (Year) 2015.

Notary Public Signature:

Commission Expiration Date* (Month) 8 /(Day) 11 /(Year) 2019

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Notary Stamp Here

DEBORAH MARIE BROOKS
Notary Public
State of New Jersey
My Commission Expires Aug 11, 2019

Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856

330952 BC

215436841

DEPARTMENT OF SOCIAL SERVICES – MISSOURI DIVISION OF HEALTH

CERTIFICATE OF LIVE BIRTH

STATE FILE NUMBER 124 82 205801

WRITE S STUB

FILED SEP 28 1982

REGISTRATION DISTRICT NO. _____ PRIMARY REGISTRATION DISTRICT NO. _____ REGISTRAR'S NO. _____

VS 100 Rev. 1/78

CHILD

CHILD–NAME (1. First / Middle / Last)	SEX (2.)	DATE OF BIRTH (Mo., Day, Yr.) (3a.)	HOUR (3b.)
Sarah / Rachel / Pickle	Female	Aug. 30, 1982	3:13p M

HOSPITAL–NAME (If not in hospital, give street and number) (4a.)	CITY, TOWN OR LOCATION OF BIRTH (4b.)	COUNTY OF BIRTH (4c.)
Jewish Hospital of St. Louis	St. Louis	--

CERTIFIER

I certify that the stated information concerning this child is true to the best of my knowledge and belief.

5a. (Signature) ▶	DATE SIGNED (Mo., Day, Yr.) (5b.)	NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or print) (5c.)
Justin F Kraner	9-10-82	M.D.

CERTIFIER–NAME AND TITLE (Type or print) (5d.)	MO. LICENSE NO. (5e.)	MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip) (5f.)
Justin F. Kraner, M.D.	23859	2821 N. Ballas, St. Louis, Mo. 63131

REGISTRAR (6a. (Signature) ▶)	DATE RECEIVED BY REGISTRAR (Month, Day, Year) (6b.)
Arnold Montgomery	SEP 28 1982

MOTHER

MOTHER–MAIDEN NAME (7a. First / Middle / Last)	AGE (At time of this birth) (7b.)	STATE OF BIRTH (If not in U.S.A., name country) (7c.)
Vicki / Esther / Schulman	26	Missouri

RESIDENCE–STATE (8a.)	COUNTY (8b.)	CITY, TOWN OR LOCATION (8c.)	STREET AND NUMBER OF RESIDENCE (8d.)	INSIDE CITY LIMITS (Specify yes or no) (8e.)
Missouri	Jefferson	High Ridge	1996 Antire Rd.	No

MOTHER'S MAILING ADDRESS–If same as above, enter Zip Code only (9.) 63049

FATHER

FATHER–NAME (10a. First / Middle / Last)	AGE (At time of this birth) (10b.)	STATE OF BIRTH (If not in U.S.A., name country) (10c.)
Bobby / Neil / Pickle	37	Washington

I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.

11a. (Signature of Parent or other Informant) ▶	RELATION TO CHILD (11b.)
Vicki Pickle Vicki Pickle	Mother

TYPE OR PRINT IN

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

THIS IS A CERTIFIED COPY OF AN ORIGINAL DOCUMENT

(Do not accept if rephotographed, or if seal impression cannot be felt)

THE REPRODUCTION OF THIS DOCUMENT IS PROHIBITED BY LAW (CHAP. 193.380 RSMo 1969)

STATE OF MISSOURI } ss
CITY OF JEFFERSON }

I HEREBY CERTIFY that this is an exact reproduction of the certificate for the person named therein as it now appears in the permanent records of the Bureau of Vital Records of the Division of Health of Missouri. Witness my hand as State Registrar of Vital Statistics and the Seal of the Division of Health of Missouri this date of

OCT 1 1982

Joseph B. Reichart
Joseph B. Reichart
State Registrar of Vital Statistics

330952

Section IV

Medical Education

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

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

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

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: University of Cincinnati College of Medicine

Address Line 1: Program Director Academic/UC College of Medicine

Address Line 2: Office of Student Affairs, RM E251M

City: Cincinnati **State/Province:** OH **Zip Code (Postal Code):** 45267-0552

Country: US

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

Premedical Education:
Years of education required for admission to your medical school: 4
Credential/degree presented by the applicant for admission to your medical school: BA

Enrollment and Participation: Our records indicate that Pickle, Sarah
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 4 years of medical education on the following dates: **From:** 08/15/2005 (Month Day Year) **To:** 05/22/2009 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 06/13/2009 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

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

Watermark
For FCVS internal use only.

Name: Kim Schiesler

Signature: *Kim Schiesler*

Title: Assistant Registrar
Date of Signature: 02/05/2015 **Phone:** (513) 558-5579
Fax: (513) 558-1100 **Email:** schieski@UCMAIL.UC.EDU

ELECTRONIC SEAL VERIFIED

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

Unusual Circumstances

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

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

	From Date:	**To Date:**
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:		
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? **No**

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

	From Date:	**To Date:**
Academic Probation _____		
Probation for unprofessional conduct/behavioral _____		
Other:		

Please specify a reason:

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

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

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Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Sarah Pickle

University of Cincinnati College of Medicine

Unusual Circumstances

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

End of report for: Sarah Pickle

PROVIDED BY APPLICANT

Medical Student Performance Evaluation

for

Sarah Rachel Pickle

November 1, 2008

Identifying Information

Sarah Rachel Pickle is a fourth-year student at the University of Cincinnati College of Medicine in Cincinnati, Ohio.

Unique Characteristics

Sarah entered the College of Medicine through our Dual Admissions Program with Miami University in Oxford, Ohio. During her undergraduate years, she started doing research with the Department of Family Medicine helping with a study of the prevalence of incidents of intimate partner violence among older women in primary care practices. She has sustained her interest in clinical research and, during her freshman year of medical school, was accepted into the Art of Family Medicine Medical Student Scholars Program, which is a four-year non-credit elective which involves not only clinical research opportunities, but exposure to additional clinical training and study groups regarding patient-centered care She is currently investigating barriers faced by medical students in accessing international health care experiences and in developing programs to facilitate this kind of experience for students. Sarah has been very active during medical school in both school and community service. During all four years of medical school, she has been a volunteer with MEDVOUC, a student-run organization that provides free medical care at a local homeless shelter. She served as Education Coordinator for this group and she has also been a speaker for DOC Talks, another student-run organization that provides lectures to middle school and high school students on basic public health issues. During the summer following her first year of medical school, Sarah participated in the Ohio SEARCH Internship as part of the Family Medicine Scholars Program. She participated in the Global Health Education Consortium in the Dominican Republic in 2007 and the Ohio Academy of Family Physicians Annual Student Retreat the same year. Sarah is active with Medical Students for Choice and attended their regional conference in 2006. At school Sarah was the student representative on the Curriculum Committee for the third and fourth year. Lastly, Sarah's talents as a singer and video producer have greatly enriched student life. She and several of her classmates started a video production group called the T9 Champions in 2006. They initially did several humorous videos for talent shows. Recognizing their wonderful talent, the College of Medicine Student Affairs Office commissioned them to do several videos for educational purposes. They are incredibly creative, polished and technically impressive. Sarah also sings with the College of Medicine Women's Chorus, which performs at talent shows and the annual scholarship benefit concert. Sarah is a member of the American Academy of Pediatrics, the American Academy of Family Physicians and the American Medical Women's Association. Of interest, Sarah has maintained an FCC Advanced Class amateur radio license since 1994.

Academic History

Ms. Pickle received a B.A. Magna Cum Laude in Microbiology from Miami University-Oxford in 2005. She matriculated at the University of Cincinnati College of Medicine in August, 2005.

Date of Expected Graduation from Medical School: 06/01/2009

Date of Initial Matriculation in Medical School: 08/15/2005

Please explain any extensions, leave(s) of absence, gap(s), or break(s) in the student's educational program.

For transfer students:

Date of Initial Matriculation in Prior Medical School:

Date of Transfer from Medical School:

For dual/joint/combined degree students:

Date of Initial Matriculation in Other Degree Program:

Medical Student Performance Evaluation

for

Sarah Rachel Pickle

November 1, 2008

Date of Expected Graduation from Other Degree Program:

Type of Other Degree Program:

Was this student required to repeat or otherwise remediate any coursework during his/her medical education?:	No
Was this student the recipient of any adverse action(s) by the medical school or its parent institution?:	No

Academic Progress

Preclinical/Basic Science Curriculum:

She satisfactorily completed all courses of the first two years of the curriculum. Honors grades were received in Brain & Behavior I, Clinical Foundations Medical Practice II, Brain & Behavior II. High Pass grades were received in Microbiology & Immunology, Medical Pharmacology, Principles of Pathology.

She has met the College's requirement to pass the USMLE STEP I Examination of the National Board of Medical Examiners. Total test score: **241**.

Core Clinical Clerkships and Specialty Clerkships:

PSYCHIATRY CORE CLKSP: Honors

Sarah had an outstanding performance on her Psychiatry rotation. She received Honors in every grading category (fund of knowledge, history taking, mental status exams, written skills, oral presentation skills, interpersonal communication, self-education/learning habits, problem-solving, clinical judgment and professionalism). Sarah's preceptors commented that Sarah was one of the best medical students that they had worked with. Her clinical knowledge was impressive and she was always interested in learning more about the patients' experience of mental illness. Sarah showed great empathy and consideration for the patients. She was willing to work in the clinic presenting patients and writing notes. She asked intelligent questions and utilized her time efficiently and effectively. Her familiarity with psychotherapy terms and practice was beyond her peers. Her clinical judgment was good and she worked well with patients and staff. Sarah will do well in whatever area of medicine she chooses to pursue.

DERMATOLOGY SPECIALTY CLKSP: Honors

very good student

PEDIATRICS CORE CLKSP: Honors

On the inpatient rotation, Sarah was an excellent student, definitely above expectation for a student at her level. She was very energetic, studious, inquisitve and thorough in her history taking. Her presentations are excellent. On her observed bedside exercise, Sarah was graded above the level expected for training for her history, physical examination and presentation. Sarah's ambulatory assignment was in the CCHMC emergency department and primary care clinic. Sarah completed excellent history and physical exams, the documentation was appropriate and her presentations were concise, accurate and thorough. Her knowledge base was above expected for her level of training. She had excellent interpersonal skills and was comfortable taking sensitive social histories. She was consistently reading and very receptive to feedback.

Medical Student Performance Evaluation

for

Sarah Rachel Pickle

November 1, 2008

She had an excellent work ethic, willing to stay late and arrives early to review patient histories prior to their arrival. She is very conscientious and always acted in a professional manner. In the emergency department, Sarah exhibited a very strong fund of knowledge. She possessed excellent communications skills. She was thorough in her history taking with subsequent outstanding formulations of assessment and plan. Sarah has a great attitude toward learning and was highly motivated. Her presentations are strong as well as her listening skills. She is organized and a self learner. She was well above her peers in her performance clinically. On the newborn nursery, Ms. Pickle was an outgoing young women. She got along well with the residents, hospital staff and the patients. She was always on time and prepared. Her clincal presentations and assessements were above most of her peers. She asked appropriate questions. She was a hard worker willing to go the extra mile. In the case based teaching sessions, she had excellent preparation and a very good fund of knowledge. She was the "organizer" of her group and was clearly interested in pediatric primary care issues.

INTERNAL MEDICINE CORE CLKSP: Honors

Inpatient: Sarah's physical examination skills, problem solving, and clinical judgment were above average. Her fund of knowledge, history-taking skills, written and oral presentation skills, communication skills, and self-education skills were outstanding. This was an excellent performance. Sarah performed excellent presentations on patients admitted the prior day. They were concise, comprehensive, and included a well thought out assessment and plan. Daily rounding skills were excellent. She actually had the best bedside presentations of the team. She gave small talks on medical issues related to the patient the day after admission. Her areas of strength were her knowledge base, written documentation, and presentation skills.

Ambulatory: The student clinic preceptor rated all of Sarah's clinical skills in the above average category. The preceptor noted that Sarah was very well organized and efficient in her work. She had no trouble interviewing and examining patients and making a concise plan. Her notes were very systematic and her H & Ps were easy to follow. She had a good rapport with patients and staff. Sarah was energetic, reliable, and had a good fund of knowledge. The community preceptor rated the Sarah's clinical skills in the above average to outstanding categories. The preceptor felt that Sarah was one of the best students that she had worked with. She kept up with the pace of the patient flow and was a big help in the clinic. Her areas of strength were her work ethic, pleasant personality, and time management skills.

OBSTETRICS/GYN CORE CLKSP: Honors

Ms. Pickle performed her third year obstetrics and gynecology core clerkship at the Bethesda North Hospital, which included a two-week ambulatory preceptorship in the outpatient clinic of that hospital. Her clinical evaluations were all in the Honors category with a grade of 99% for her performance on the obstetrical service, 90% on the gynecology service and 99% for her outpatient rotation. She demonstrated particular strengths in the areas of written skills, self-education and learning habits, and professionalism. The following comments were made by those who worked with her: "She is bright, easy to work with and a pleasure to have on the service. Sara is one of the best students we have ever had."

On the objective measures of the rotation she received a grade of 94% for her small group quiz average, 89% on the department exam, 74% on the SHELF exam and 86% on her oral exam. At the end of the clerkship her skills in performing the breast and pelvic exam were evaluated by gynecological teaching associates, and she performed well in all areas. A special note was made that she had excellent breast exam skills.

In summary, Ms. Pickle was a very bright and enthusiastic student who impressed everyone she worked with. She was an integral member of the team and functioned at the level of an intern. In small group learning sessions she was a very active participant and contributed greatly to the group's understanding of the material. She is an energetic student who will do well in whatever field she chooses. Several have encouraged her to pursue OB/GYN as a career.

RADIOLOGY SPECIALTY CLKSP: Pass

Ms. Pickle completed the coursework satisfactorily in the Radiology Specialty Clerkship rotation.

Medical Student Performance Evaluation

for

Sarah Rachel Pickle

November 1, 2008

EMERGENCY MEDICINE SPEC CLKSP: Honors

Ms. Pickle did extremely good work during her 3rd year Emergency Medicine clerkship. She was noted to have a fund of knowledge that was well above average for her class group. She had well developed history taking skills and physical examination skills allowing her to identify all major points and many subtleties. She was very effective in the presentation of information in oral format and had written records which were extremely clear, concise, and to the point. She has superior communication skills and was able to form a very ready rapport with patients that she saw while on the clerkship, and was very effective in her interpersonal relationships with her co-workers. She was noted to be very strong in the performance of procedures and technical aspects of the rotation. She was able to arrive at a very complete and comprehensive differential diagnosis and problem list on patients that she saw. She exhibited clinical judgment in the formulation of treatment plans and disposition decisions that was well beyond what would be expected for her level of training. In terms of professional conduct, she exceeded all expectations. She was noted to be very active in reading about clinical problems she encountered while on the clerkship and was very aggressive about augmenting her knowledge base in other ways. She was an extremely dependable student who completed all assigned task without prompting, and frequently anticipated the needs of her resident and patients.

FAMILY MEDICINE CORE CLKSP: Honors

Sarah was in a faculty residency site for her Family Medicine clerkship. Her preceptor stated that she was a self-starter, already at the level of a fourth year medical student, a highly motivated learner and a pleasure to work with. She had a very thorough and thoughtful approach to history taking and her presentations were described as excellent, well organized and complete. Sarah was time efficient in seeing patients as well as respectful of patients, family and staff.

SURGERY CORE CLKSP: Pass

Sarah passed the departmental test and quizzes. She scored 68.7 on the NBME written Surgery exam. The mean score on all tests has been converted to 70. The range of scores on the written exam for the students in this clerkship was 55.7 - 88.7. She passed the oral exam. The oral exam was pass/fail.

On the clinical rotations (Heuer 80, Urology 100) (clinical rotation evaluation scores range from 0 = failing to 100 = excellent), Sarah was interested and prepared. She demonstrated a good fund of knowledge with few gaps in the understanding of surgical principles. She has good problem solving ability and clinical judgment. Her written documentation was legible and accurate. Her oral presentations were complete and concise. She quickly established rapport with patients and families. She is prompt, courteous and professional. Sarah functioned at the level of a resident and will be a wonderful physician. Sarah has good potential for residency training.

ACTING INTERNSHP-INT MEDICINE: Honors

Sarah's first month of acting internship was performed at the University Hospital in July. This was the first rotation of the fourth year. Sarah's physical examination skills were **above average**. Her fund of knowledge, history-taking skills, written and oral presentation skills, communication skills, self-education skills, problem solving, and clinical judgment were **outstanding**. The attending physician commented that Sarah was one of the best acting interns that he had encountered during his eleven years of attending at University Hospital. It was clear as early as the second day of the rotation that she was a cut above. She was bright, motivated, interested, and had a caring attitude. At the bedside, it was clear that she connected with her patients and she was truly interested in their well being. Her resident trusted her with difficult patients and felt she was a "go to" type of student. Her areas of strength were her fund of knowledge, work ethic, caring attitude, and patient rapport.

CHILD ABUSE OP: Honors

According to her attending, Sarah easily falls into the "one of the best students I have ever taught" category. Her strengths were communication, decision making and fund of knowledge. She pushes herself to improve. She should strongly

Medical Student Performance Evaluation

for

Sarah Rachel Pickle

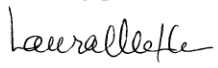
November 1, 2008

consider Pediatrics as a career.

Summary:

In the first year of medical school, Sarah passed all coursework and earned Honors in Brain and Behavior, the integrated Neuroscience course. During her second year of medical school, she began to really excel and received straight Honors and High Pass grades in all of the coursework. Her performance in her clinical clerkships has been truly outstanding with Honors in the vast majority of the required clerkships and early electives. She has received Honors in Psychiatry, Dermatology, Pediatrics, Internal Medicine, Obstetrics/Gynecology, Emergency Medicine and Family Medicine. She also received Honors for the Acting Internship in Internal Medicine, which she did as the first rotation of her fourth year, and a clinical elective in child abuse. Sarah is rated as "one of the best students that we've had" by many of her preceptors. She is clearly a gifted student who, by virtue of her gift of great intelligence and her wonderful personality and work ethic, puts in an outstanding performance in every rotation. She receives outstanding reviews for all the key competencies. She is a mature and insightful student. She is clearly academically gifted and shares these gifts generously as an eager participant in rounds and teaching activities. She connects easily with patients and was adept at managing difficult and challenging personalities. Many of her evaluators commented that she functioned at the level of a resident.

In summary, based on the information provided above, and on behalf of the University of Cincinnati College of Medicine, it is a pleasure to recommend Ms. Pickle to you. We consider her to be an OUTSTANDING candidate for a residency position.



Signature of School Official

Laura Wexler

Name of School Official

Senior Associate Dean of Admissions and Student Affairs

Title

Laura.Wexler@uc.edu

E-mail address

DEAN'S LETTER RATING CATEGORIES - 2009
GRADUATING CLASS OF THE UNIVERSITY OF CINCINNATI

To the best of our ability, the Dean's letter provides an accurate description of this student and should be read in its entirety. Surveys sent to program directors over the past several years indicate that our graduates tend to perform very well and that, on the whole, the Dean's letters do not tend to overrate our students.

Recognizing that class rankings are imprecise and not necessarily the best indicators of a student's potential as a resident, we nevertheless have developed a ranking system which will allow a student's course grades to be compared to those of his/her colleagues. The method adopted by the college is to **give the greatest weight to those courses with the largest credit hours.** A type of GPA which is the determinant for ranking is calculated **by adding the combined Year I and II GPA to the Year III GPA and dividing the total by two.** The yearly grade point averages are calculated by multiplying **the credit hours of each course by a numerical value assigned to the grade** earned, summing the products, and dividing the sum by the total number of credit hours taken.

We have reviewed the grade distribution and program director feedback over the past several years, and have divided the class into five groups. We think that the adjective describing the students in each group is a **reasonable estimate** of that student's potential for residency training.

CATEGORY	APPROXIMATE PERCENTILE	DESCRIPTION
Outstanding	80-99	Students have usually received *13 -21 Honors and High Pass designations. Most are AOA.
Excellent	60-79	Students usually have achieved *8-14 Honors and High Pass designations. Some are AOA.
Very Good	30-59	Students have achieved *4-11 Honors and High Pass designations. In clinical evaluations, they have consistently been viewed as above average.
Good	10-29	Students are solidly passing and have functioned effectively as clinical clerks. Many of these students have *3-5 Honors and High Pass designations.
Recommend	1-9	Students have passed all courses. Most have received *1-2 High Pass designations. Some may have had occasion to repeat examinations or courses. They are rated as clinically competent.

*** See Description Above.**

Appendix E

Medical School Information Page

University of Cincinnati College of Medicine
Medical School Name

Cincinnati, Ohio
City, State

Special programmatic emphases, strengths, mission/goal(s) of the medical school:

The UCCOM provides both outstanding research facilities and strong clinical and teaching experiences. Graduates are ranked as highly competitive by national residency program directors and choose careers in a broad range of specialty areas, as well as primary care fields. Extensive research opportunities are available. Overall rankings from the NIH for FY04 placed the COM 19th nationally among public medical colleges and 42nd among all medical schools for sponsored program awards. Students train in both academic health center and community hospitals.

Special characteristics of the medical school's educational program:

Using an integrated curricular approach, including laboratory, small group discussions, team-based learning and lectures, the first two years provide students with scientific and humanistic principles of medicine. Clinical exposure begins early in the first year, using a state of the art standardized patient clinical skills laboratory. During the third year, students rotate through seven core clerkships and begin exploring career options by participating in subspecialty electives. Year four includes two required Acting Internships in Internal Medicine, a required selective in Neuroscience, and an AHEC rotation. Students choose from over 100 elective offerings.

Average length of enrollment (initial matriculation to graduation) at the medical school:

4
Years Months

Description of the evaluation system used at the medical school:

Evaluation system includes both objective and subjective evaluations. Students are required to take USMLE shelf exams during all of the major core clerkships in the third year and also must pass a required clinical skills examination.

Medical school requirements for successful completion of USMLE Step 1,2 (check all that apply):

USMLE Step 1:

- ☐ Required for promotion
- ☑ Required for graduation
- ☐ Required, but not for promoting/graduation
- ☐ Not required

USMLE Step 2:

- ☐ Required for promotion
- ☑ Required for graduation
- ☐ Required, but not for promoting/graduation
- ☐ Not required

Medical school requirements for successful completion of Objective/Observed Structured Clinical Evaluation (OSCE) at medical school. OSCEs are used for (check all that apply):

- ☑ Completion of course
- ☑ Completion of clerkship
- ☑ Completion of third year
- ☑ Graduation
- ☐ Other:

Utilization of the course, clerkship, or elective director's narrative comments in composition of the MSPE. The narrative comments contained in the attached MSPE can best be described as (check one):

- [x] Reported exactly as written
- [ ] Edited for length or grammar but not for content
- [ ] Edited for content or included selectively

Utilization by the medical school of the AAMC "Guidelines for Medical Schools Regarding Academic Transcripts." This medical school is:

- [ ] Completely in compliance with Guidelines' recommendations
- [x] Partially in compliance with Guidelines' recommendations
  Exceptions: Record Election to AOA
- [ ] Not in compliance with Guidelines' recommendations

Description of the process by which the MSPE is composed at the medical school (including number of school personnel involved in composition of the MSPE).

The Associate Dean writes the paragraphs on unique characteristics and the summary paragraph, as well as any required paragraph on academic remediation, leaves of absence, and adverse actions. Objective data and clinical evaluations are pulled from our student database.

Student are permitted to review the MSPE prior to its transmission:

- [x] Yes
- [ ] No

Academic Record of: SARAH R. PICKLE

Student ID: M02543746
Student SSN: REDAC
Date of Birth: 08/30/xxxx
Program: MD

University of Cincinnati
College of Medicine

Office of the Registrar
231 Abert Sabin Way
Cincinnati, Ohio 45267-0552

COURSES OF INSTRUCTION

FIRST YEAR 8/15/2005 - 6/6/2006

COURSE INFORMATION		CR HRS	GRADE
26989142	MEDICAL BIOCHEM & HUMAN GEN	12	P
26910171	MICROSCOPIC ANATOMY	12	P
26950102	CLINICAL FOUNDATIONS OF MED PRAC I	14	P
26910102	GROSS ANATOMY	14	P
26968142	MEDICAL PHYSIOLOGY	12	P
26950110	BRAIN & BEHAVIOR I	14	H

SECOND YEAR 8/14/2006 - 5/8/2007

COURSE INFORMATION		CR HRS	GRADE
26936271	MICROBIOLOGY & IMMUNOLOGY	10	HP
26965242	MEDICAL PHARMACOLOGY	12	HP
26950203	CLIN FOUNDATIONS MED PRAC II	16	H
26955202	PRINCIPLES OF PATHOLOGY	24	HP
26950210	BRAIN & BEHAVIOR II	10	H

THIRD YEAR 7/2/2007 - 6/20/2008

COURSE INFORMATION		CR HRS	GRADE
26963371	PSYCHIATRY CORE CLKSP	12	H
26944375	DERMATOLOGY SPECIALTY CLKSP	4	H
26961373	PEDIATRICS CORE CLKSP	16	H
26931373	INTERNAL MEDICINE CORE CLKSP	16	H
26946373	OBSTETRICS/GYN CORE CLKSP	16	H
26971375	RADIOLOGY SPECIALTY CLKSP	4	P
26923375	EMERGENCY MEDICINE SPEC CLKSP	4	H
26920371	FAMILY MEDICINE CORE CLKSP	8	H
26980373	SURGERY CORE CLKSP	16	P

FOURTH YEAR 7/1/2008 - 5/22/2009

COURSE INFORMATION		CR HRS	GRADE
26931472	ACTING INTERNSHP-INT MEDICINE	12	H
160114	CHILD ABUSE OP	8	H
26950402	ICP IV: CLIN COMPETENCY EXAM	0	P
060102	ACT INTERN FAMILY MEDICINE	8	H
110199	OBSTETRICS & GYNECOLOGY AWAY	8	H
060111	PRECEPT IN FAM MED AHEC OP	8	H
26950441	CLIN NEUROSCIENCE SELECTIVE	8	H
26931472	ACTING INTERNSHP-INT MEDICINE	12	H
060166	COMPLEMENTARY MEDICINE OP	8	HP
210106	CLINICAL DIAGNOSTIC RADIOLOGY	8	H
060111	PRECEPT IN FAM MED AHEC OP	8	H

COMMENTS

Elected into Alpha Omega Alpha, September 2008.
POSTGRADUATE ASSIGNMENT: FAMILY MEDICINE - Thomas Jefferson Univ-PA

PASSING SCORE ON USMLE STEP 1, STEP 2 CK AND CS REQUIRED FOR GRADUATION.

Date: [illegible]

M.D. Conferred: 06/13/2009

AN OFFICIAL SIGNATURE IS WHITE WITH A GREEN BACKGROUND REJECT DOCUMENT IF SIGNATURE BELOW IS DISTORTED

Barbara A. Gadzinski, Medical Registrar

RAISED SEAL NOT REQUIRED
This official transcript is printed on green SCRIP-SAFE® security paper and does not require a raised seal.
For electronic purposes only.

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University of Cincinnati
College of Medicine
231 Albert Sabin Way
P. O. Box 670552
Cincinnati, OH 45267

Grade Policy

Grade	Description	Effective Dates
H	Honors	discontinued 2011 years 1 & 2
HP	High Pass	added 1989 years 3 & 4; added 1990 years 1 & 2; discontinued 2011 years 1 & 2
P	Pass	added 2011 P/F grading system years 1 & 2
RP	Remediated Pass	added 1990, discontinued 1996
C	Conditional	added 2011
R	Remediate	added 1996; discontinued 2011
F	Fail	added 2011 P/F grading system years 1 & 2
E	Exempt	discontinued 2011
I	Incomplete	
W	Withdraw	
WP	Withdraw Passing	added 1989
WF	Withdraw Failing	added 1989
AU	Audit	added 1989; discontinued 2011

Curriculum
The University of Cincinnati College of Medicine implemented a revised curriculum in August of 2011 that integrated biomedical, clinical, and psychosocial sciences with clinical skills and professional identity throughout the four-year curriculum. The first and second year medical students are evaluated using a pass/fail system. Third and fourth year students are evaluated using an honors/high pass/pass/fail system. The 2015 Graduation class is the inaugural class of this revised curriculum.

USMLE Statement
Passing Score on USMLE Step 1, Step 2 CK and Step 2 CS required for graduation.

FERPA Statement
Disclosure of information contained in this transcript may not be made to another party without prior written consent of the student whose name appears herein. This information may be used solely by the individual or institution to which it was originally released for the purpose for which the disclosure was made.

Accreditation Statement
University of Cincinnati is accredited by the North Central Association of Colleges and Schools as a degree-granting institution at the associate, baccalaureate, master's, professional and doctoral levels. In addition to this comprehensive accreditation, the University of Cincinnati College of Medicine is accredited by the Liaison Committee on Medical Education (LCME) as a degree-granting institution for the MD degree.

ELECTRONIC SEAL VERIFIED

The Board of Trustees of the

University of Cincinnati

on the recommendation of the Faculty of the

College of Medicine

of the University, does hereby confer upon

Sarah Rachel Pickle

the degree of

Doctor of Medicine

with all the rights and privileges appertaining thereto. Given at Cincinnati, Ohio this thirteenth day of June, two thousand and nine.

H C Buck Niehoff
Chairperson of the Board of Trustees

C. Francis Barnett
Secretary of the Board of Trustees

Interim President of the University

David Stern
Dean of the College

Section V

Graduate Medical Education

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

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

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

Verification of Graduate Medical Education

Institution: Thomas Jefferson University Hospital

Attention: Program Director

Specialty: Family Medicine

Affiliated University: THOMAS JEFFERSON UNIV.

Address: Philadelphia, PA

Verification For:

Name: Pickle, Sarah

DOB: 08/30/1982

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

Program Participation:

Important:

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

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

Report Internships, Residencies and Fellowships separately.

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

Training Level: 1 (e.g., 1, 2, 3, etc.)
- [X] Internship
- [X] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

Specialty/Subspecialty: FAMILY MEDICINE
From: 6/30/09 To: 6/30/10
Successfully Completed?: [X] Yes [ ] No [ ] In Progress
Accredited by: [X] ACGME [ ] AOA [ ] LCGME [ ] RSC [ ] CFPC [ ] RCPSC [ ] APPAP [ ] None of these

Training Level: 2-3 (e.g., 1, 2, 3, etc.)
- [ ] Internship
- [X] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

Specialty/Subspecialty: FAMILY MEDICINE
From: 7/1/10 To: 6/30/12
Successfully Completed?: [X] Yes [ ] No [ ] In Progress
Accredited by: [X] 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 [X] No
2. Was this individual ever placed on probation? [ ] Yes [X] No
3. Was this individual ever disciplined or placed under investigation? [ ] Yes [X] No
4. Were any negative reports for behavioral reasons ever filed by instructors? [ ] Yes [X] 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 [X] No

Please explain any "Yes" response from above:

Maria C. Stenta Notary 3/11/15

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Maria C. Stenta, Notary Public
City of Philadelphia, Philadelphia County
My Commission Expires Oct. 31, 2017
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

Certification:

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

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: R P McManus

Signature: R P McManus

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

Date of Signature: 3/11/15 PM

Tel: 215 955 0643 Fax: 215 923 9186 E-Mail: patricia.mcmanus@jefferson.edu

Rev. 03/09/2015

FCVS ID: 330952 FID: 215436841 CODE: 112416

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: Sarah Pickle
Thomas Jefferson University Hospital
Family Medicine

Unusual Circumstances

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

End of report for: Sarah Pickle

PROVIDED BY APPLICANT

Thomas Jefferson University Hospital

Philadelphia, Pennsylvania

This is to certify that

Sarah Pickle, M.D.

has filled the position, and faithfully and satisfactorily performed the duties of

Resident in Family and Community Medicine

in this Hospital from June 20, 2009 to July 1, 2012.

Richard C Wender

Chairman, Department of Family and Community Medicine

Residency Director, Department of Family and Community Medicine

THOMAS JEFFERSON UNIVERSITY HOSPITALS

President, Thomas Jefferson University Hospital

Section VI

Licensure Examination History

(State Licensing Authorities Only)

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

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) 868-4000

Date : **02/09/2015**

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 330952

Examinee: Pickle, Sarah
Alt Name(s): Pickle, Sarah Rachel

Examinee ID#: 5-195-663-9
Date of Birth: 08/30/1982

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, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	06/16/2007	Pass	241	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	08/29/2008	Pass	242	(184)	

Clinical Skills (CS)*

	Test Date	Pass/Fail	Total	MP	Comments
	12/31/2008	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
PENNSYLVANIA	06/23/2010	Pass	235	(187)	

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

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) 868-4000

Examinee: Pickle, Sarah

Examinee ID#: 5-195-663-9
Date of Birth: 08/30/1982

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. **No score is reported.** Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

4/2013

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

5/1/2015

Dr. Sarah Rachel Pickle
404 Cypress Lane
East Brunswick NJ 08816-5249

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **126220** was issued on **04/30/2015** and will expire on **04/01/2016**.

Enclosed is your wallet card and wall certificate. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://med.ohio.gov in the "Licensee Profile and Status section. The website is updated immediately to reflect newly issued licenses.

The Ohio Medical Board operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. Enclosed is a chart and information outlining the staggered medical license renewal system and continuing medical education (CME) hours required. Renewal applications are mailed approximately six months prior to the date of expiration. CME information may also be obtained from the Board's website.

SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE. *A CHANGE OF ADDRESS FORM IS AVAILABLE ON THE BOARD'S WEBSITE.*

This notice authorizes you to make application for a U.S. Drug Enforcement Administration certificate of registration (controlled substance permit). To make such application, contact:

Drug Enforcement Administration (DEA)
431 Howard St.
Detroit, Michigan 48226
(800) 230-6844
www.deadiversion.usdoj.gov/

Any questions regarding the DEA registration must be directed to the DEA office.

Sincerely,

Mitchell Alderson
Chief, Licensure

Date Posted: 3/4/2016 11:07:39 PM

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

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

License Information

License Number	35.126220
License Name	Sarah Pickle

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 20-24

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

. 1-4

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

. 10-14

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

. 15-19

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

. 0

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

. 1-4

Clinical - Practice setting

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

. 20-24

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

. 0

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 45213

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

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

. . . . . 3590 Lucille Drive, Suite 2100, Cincinnati, OH 45213; 2751 O'Varsity Way Cincinnati, Ohio 45221

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. 2-5

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1043453194

DEA number

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

. . . . . FP5260853

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . YES

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . YES

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

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

Contact Audit Trail for PICKLE SARAH

Date	User	Table	Field	New	Old
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States of America	
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States of America	
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	COUNTYID	Hamilton	Out of State
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	COUNTYID	Hamilton	Out of State
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	PHONE	3143027887	(732) 235-8993
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	STATECODE	OH	NJ
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	STATECODE	OH	NJ
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	ZIPCODE	45226	08901
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	ZIPCODE	45226	08816-5249
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	CITY	Cincinnati	New Brunswick
2/9/2016 3:27:46 PM	Bates, J	CONTACTADDRESS	CITY	Cincinnati	East Brunswick
2/9/2016 3:27:45 PM	Bates, J	CONTACTADDRESS	ADDRESS1	601 Rushton Road	317 George Street
2/9/2016 3:27:45 PM	Bates, J	CONTACTADDRESS	ADDRESS1	601 Rushton Road	404 Cypress Lane
2/13/2015 10:23:22 AM	Spencer, T	CONTACT	TAXID	Redacted	
2/13/2015 10:23:03 AM	Spencer, T	CONTACT	DATEOFBIRTH	19820830	
2/13/2015 10:23:03 AM	Spencer, T	CONTACT	BIRTHCITY	St. Louis	
2/13/2015 10:23:03 AM	Spencer, T	CONTACT	BIRTHSTATE	MO	
2/13/2015 10:23:03 AM	Spencer, T	CONTACT	GENDER	F	
2/13/2015 10:03:10 AM	Spencer, T	CONTACTADDRESS	CITY	East Brunswick	
2/13/2015 10:03:10 AM	Spencer, T	CONTACTADDRESS	ZIPCODE	08816-5249	
2/13/2015 10:03:10	Spencer, T	CONTACTADDRESS	PHONE	(314) 302-7887	

AM					
2/13/2015 10:03:10 AM	Spencer, T	CONTACTADDRESS	COUNTYID	Out of State	
2/13/2015 10:03:10 AM	Spencer, T	CONTACTADDRESS	ADDRESS1	404 Cypress Lane	
2/13/2015 10:02:26 AM	Spencer, T	CONTACTADDRESS	ADDRESS1	317 George Street	
2/13/2015 10:02:26 AM	Spencer, T	CONTACTADDRESS	CITY	New Brunswick	
2/13/2015 10:02:26 AM	Spencer, T	CONTACTADDRESS	STATECODE	NJ	OH
2/13/2015 10:02:26 AM	Spencer, T	CONTACTADDRESS	ZIPCODE	08901	
2/13/2015 10:02:26 AM	Spencer, T	CONTACTADDRESS	PHONE	(732) 235-8993	
2/13/2015 10:02:26 AM	Spencer, T	CONTACTADDRESS	COUNTYID	Out of State	
2/13/2015 10:01:19 AM	Spencer, T	CONTACT	TITLE	Dr.	
2/6/2015 1:58:09 PM	Dillard, P	CONTACT	OLRPASSWORD	*******	*******