MD2040373

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

BOARD OF MEDICINE

DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

## SE APPLICATION FOR MEDICINE AND OSTEOPATHY (MD & DO)

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

### SECTION 1A. LICENSURE TYPE & FEES

**SELECT LICENSURE TYPE:**

- [X] Medicine & Surgery (MD)
- [ ] Osteopathy & Surgery (DO)

**SELECT GRADUATE TYPE:**

- [X] U.S./ Canadian Graduate
- [ ] International Graduate

### SECTION 1B. BASIS OF APPLICATION

*Select the basis by which you are applying:*

EXAM COMPLETED: $805.00

- [X] USMLE
- [ ] NBME
- [ ] NBOME
- [ ] LMCC
- [ ] FLEX
- [ ] COMLEX
- [ ] COMVEX
- [ ] State Exam

USMLE STEP 3: [ ] Exam $288.00 [ ] Re-Exam $85.00

EMINENCE:
[ ] Eminence 1: $805.00 [ ] Eminence 2: $2000.00

### SECTION 2A. APPLICANT INFORMATION

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

PENG | | YE | (SUFFIX: Jr., Sr. etc.)
FIRST NAME | MI | LAST NAME

DEGREE(S): [X] M.D., [ ] D.O, [ ] PH.D., [ ] OTHER DEGREE _____

Date of Birth | Social Security Number | GENDER: [ ] MALE [X] FEMALE

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

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

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

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

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

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

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

- [ ] American Indian/Alaskan Native
- [X] Asian/South Asian
- [ ] Black or African American
- [ ] Caucasian/White
- [ ] Hispanic or Latino
- [ ] Other _____
- [ ] Native Hawaiian or other Pacific Islander

### LANGUAGE(S) SPOKEN:

*Language(s) spoken other than English:*

_____
_____
_____

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

BOARD OF MEDICINE

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

### SECTION 3A. PREFERRED MAILING ADDRESS

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

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

☑ HOME ADDRESS ☐ BUSINESS ADDRESS

### SECTION 3B. HOME ADDRESS

*THIS INFORMATION WILL NOT BE MADE AVAILABLE TO THE PUBLIC.*

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

APARTMENT #_____ HOME PHONE NUMBER: ___ ___ ____ HOME FAX: (____) ____ - ____

EMAIL ADDRESS _____

### SECTION 3C. BUSINESS ADDRESS:

*THIS INFORMATION WILL BE MADE AVAILABLE TO THE PUBLIC.*

BUSINESS NAME: University Hospitals Case Medical Center

BUSINESS ADDRESS: 11100 Euclid Ave. Cleveland OH 44106
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

☐ SUITE #_____ ☐ FLOOR#_____

BUSINESS PHONE NUMBER: (216) 844-8551 BUSINESS FAX: (____) ____ - ____

EMAIL ADDRESS: peng.ye@uhhospitals.org

### IMPORTANT MESSAGE TO ALL PHYSICIANS

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

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

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

BOARD OF MEDICINE

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

### SECTION 4A. POST SECONDARY SCHOOLS ATTENDED

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

| School Name, City, State, Country | Date of Graduation mm/yyyy | Degree/Certificate |
|---|---|---|
| Case Western Reserve University School of Med | 05/2008 | MD |
| Case Western Reserve University Cleveland, OH, USA | 05/2004 | B.S |
| Ohio State University Columbus, OH | N/A | none |

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

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

| Organization/Institution | Start Date mm/yyyy | End Date mm/yyyy | Type of Position (Use Key Code Below) |
|---|---|---|---|
| University Hospitals Case Medical Center | 06/2008 | 06/2012 | C |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**TRAINING AND PRACTICE DESCRIPTIONS/TYPE OF POSITION KEY CODE**

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

### SECTION 4C. MEDICAL LICENSES IN OTHER STATES/JURISDICTIONS

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

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

| Jurisdiction | Issue Date mm/yyyy | Expiration Date mm/yyyy | License Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

BOARD OF MEDICINE

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

### SECTION 5A. PRACTICE TIME IN THE DISTRICT

**Please provide practice information**

(1.A) Do you plan to practice in the District of Columbia? ☒ Yes ☐ No

(1.B) What type of medical practice? ☐ Academic ☐ Administrative ☒ Clinical ☒ Research

| (1.C.) How many hours will you practice in the District of Columbia? | <less than 20 hours/week | >more than 20 hours/week |
|---|---|---|
| • ACADEMIC MEDICINE | | |
| • ADMINISTRATIVE MEDICINE | | |
| • CLINICAL MEDICINE | | X (21) |
| • RESEARCH MEDICINE | | X (20) |

(2) Please indicate if you do or will practice in: ☐ Maryland ☐ Virginia

### SECTION 5B. SPECIALTIES

**Please select the appropriate specialties.**

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

Secondary _____

**SPECIALTY CODE**

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

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

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

Other: _____

**BOARD CERTIFICATION(S)**

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

Please list certifying organization(s)

_____ _____ _____

_____ _____ _____

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

### SECTION 5C. REQUIRED SCREENING QUESTIONS

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

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

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

BOARD OF MEDICINE

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

### SECTION 6A. SUPPORTING DOCUMENTS

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

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

### SECTION 6B. CONTROLLED SUBSTANCE REGISTRATION

**Will you be applying for a DC controlled substance license?**

- [x] **YES**
- [ ] **NO**

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

### SECTION 6C. PAYMENT/MAILING INFORMATION

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

**MAIL YOUR APPLICATION PACKAGE AND CHECK TO:**
*Health Professional Licensing Administration*
*Board of Medicine – Processing Center –*
*899 North Capitol Street, NE (First Floor)*
*Washington, DC 20002*

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

BOARD OF MEDICINE

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

**SECTION 7A.**

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

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

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

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

- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 8*** (Litter Control Administrative Act of 1985);
- Fines or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 9*** (Illegal Dumping Enforcement Act of 1994);
- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 2, Chapter 18*** (Civil Infractions Act of 1985);
- Past due taxes;
- Past due District of Columbia Water and Sewer Authority service fees; or
- Fines or penalties assessed pursuant to ***D.C. Official Code Title 50, Chapter 23*** (Traffic Adjudication)?

**Yes** ☐ **No** ☒

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

**SECTION 7B. LICENSEE AFFIDAVIT**

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

| LICENSEE SIGNATURE | PRINT NAME | DATE |
|---|---|---|
| [signature] | Peng Ye | 12/20/11 |


Ohio
DRIVER LICENSE
1852TY3132470000
USA
1 YE
2 PENG
2 07-16-2011
4d DLN
9 CLASS 4b EXPIRES 3a ENDORS 12 RESTR
D 07-16-2015
B
15 Sex F 16 Ht 5-04 17 Wt 130
18 Eyes BRO 19 Hair BLK

Rev. 10/11 MEDICINE & OSTEOPATHY

# DC Department of Health
# Board of Medicine Character Reference Form

Board of Medicine
899 North Capitol St., NE 1st Flr.
Washington, DC 20002
(202)-724 4900

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

University Hospital Care Medical Center

Peng Ye

Please clearly print/ type name of Applicant

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

Signature of Applicant

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

1. Date and type of service: This individual served with us as an OB/Gyn Resident from 7/08 (Month/Year) to 6/12 (Month/Year). If you are responding for a training program, please provide the number of months of postgraduate training awarded 4.

2. Please evaluate: (Indicate with check mark)

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

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

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

5. Of particular value to us in evaluating any candidate regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you.

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

Date (Required): 12/1/11

Signed by: _____
Print or type name: Lisa Pemera
Title: MD, MPH

Rev. 10/11 MEDICINE & OSTEOPATHY

# DC Department of Health
# Board of Medicine Character Reference Form

Board of Medicine
899 North Capitol St., NE 1st Flr.
Washington, DC 20002
(202)-724 4900

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

University Hospitals Case Medical Center
11100 Euclid Ave.
Cleveland OH 44106

Peng Ye
Please clearly print/ type name of Applicant

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

Signature of Applicant [signature]

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

1. Date and type of service: This individual served with us as Resident from 06/24/2008 to 6/30/2012. If you are responding for a training program, please provide the number of months of postgraduate training awarded 48 months
   (Month/Year) (Month/Year)

2. Please evaluate: (Indicate with check mark)

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

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

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

5. Of particular value to us in evaluating any candidate regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you.

_____

_____

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

Date (Required): 10/14/11

Signed by: [signature]
Print or type name: Nancy J. Cossler MD
Title: program director OB/Gyn

Rev. 10/11 MEDICINE & OSTEOPATHY

# DC Department of Health
# Board of Medicine Character Reference Form

Board of Medicine
899 North Capitol St., NE 1st Flr.
Washington, DC 20002
(202)-724 4900

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

University Hospitals Case Medical Center
11100 Euclid Ave.
Cleveland, OH 44106

Peng Ye
Please clearly print/ type name of Applicant

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

Signature of Applicant

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

1. Date and type of service: This individual served with us as Resident physician from 6/18/2008 to 6/23/2012 If you are responding for a training program, please provide the number of months of postgraduate training awarded_____.
(Month/Year) (Month/Year)

Please evaluate: (Indicate with check mark)

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

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

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

5. Of particular value to us in evaluating any candidate regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you.
Dr. Ye is compassionate, skilled, professional and always calm and unflappable. You are lucky to have her!

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

Date (Required): 12/22/11

Signed by: Roya L. Rezaee MD FACOG
Print or type name: Roya L. Rezaee MD FACOG
Title: Assistant Professor

AMA
AMERICAN
MEDICAL
ASSOCIATION

## Profile Order Detail

11/14/2011

District of Columbia Board of Medicine
Antoinette Stokes
Department of Health
Board of Medicine
899 North Capital St NE, 1st Flr
Washington, DC 20002

**Profile Order Number:** 5562901
**Received Date:** 11/13/2011
**Balance*:** $0.00

* - Negative balances are enclosed in parentheses

1 Profile processed.

- Peggy Ye

AMA
AMERICAN
MEDICAL
ASSOCIATION

# Request for Investigation

Dear Physician Profile Customer:

Thank you for using ***AMA Physician Profiles.*** AMA is committed to providing your organization with accurate physician information supporting your credentialing needs. If you should receive an AMA Physician Profile with discrepant information, please report the discrepancy to the AMA for immediate investigation.

AMA staff will contact the primary source(s) to verify the requested correction and/or change. No changes will be made to the AMA Physician Masterfile until verification from the primary source(s) is received. A letter detailing investigation outcome and an updated Physician Profile, when appropriate, will be mailed to the customer address below.

There is no additional charge for this service provided that the **Request for Investigation** is received within 30 days of the original order mail date.

Submitting a Request for Investigation:

- Make changes/corrections directly on a copy of the Physician Profile.
- Provide any supporting documents (DEA certificate, birth certificate, etc). This information will assist AMA staff with their investigation.
- Include a copy of this form when mailing or faxing discrepancy requests to the AMA.

Please don't hesitate to contact the AMA Credentialing Products Unit at 800 665-2882 if you have any questions. Thank you in advance for your assistance.

Sincerely,

Department of Physician Data and Internet Services

---

**Investigation Request ePhysician Profile Customer Account Information**

Account #: _____

Name: Antoinette Stokes

Organization: District of Columbia Board of Medicine

Address: Department of Health
Board of Medicine
899 North Capital St NE, 1st Flr

City/State/Zip: Washington, DC 20002

Daytime phone: _____

**Copies of this form can be printed from the AMA ePhysician Profile Web site.*

AMA AMERICAN MEDICAL ASSOCIATION

# AMA Physician Profile

*Name and Mailing Address:*

PEGGY YE MD

*Primary Office Address:*

SAME AS MAILING ADDRESS

**Phone:** UNKNOWN

**Birthdate:**

**Physician's Major Professional Activity:** HOSPITAL BASED RESIDENTS - ALL YEARS

**Practice Specialties Self Designated by the Physician*:**

**Primary Specialty:** OBSTETRICS & GYNECOLOGY

**Secondary Specialty:**

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

**AMA membership:** MEMBER

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

**Current and/or Historical Medical School:**

CASE WESTERN RESERVE UNIV SCH OF MED, CLEVELAND OH 44106

**Degree Awarded:** Yes

**Degree Year:** 2008

AMA AMERICAN MEDICAL ASSOCIATION

# AMA Physician Profile

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

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

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

**Sponsoring Institution:** CASE WESTERN RESERVE UNIV/UNIV HOSPITALS CASE MEDICAL CENTER
**Sponsoring State:** OHIO
**Program Name:** CASE WESTERN RESERVE UNIVERSITY/UNIVERSITY HOSPITALS CASE MEDICAL CENTER PROGRAM
**Specialty:** OBSTETRICS & GYNECOLOGY
**Dates:** 06/2008 - 06/2012 (VERIFIED)

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

## Current and/or Historical Medical Licensure:

| Jurisdiction | MD/ DO | Date Granted | Expiration Date | Status | License Type | Last Reported |
|---|---|---|---|---|---|---|
| NONE REPORTED TO DATE | | | | | | |

## Current and/or Historical NPI Information:

| NPI Number | Enumeration Date | Deactivation Date | Reactivation Date | Replacement Number | Last Reported Date |
|---|---|---|---|---|---|
| None | Reported | | | | |

## ECFMG Certfication:

**Applicant Number:**

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

AMA AMERICAN MEDICAL ASSOCIATION

## AMA Physician Profile

**Federal Drug Enforcement Administration:**

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

| DEA Number * | Schedule | Expiration Date | Last Reported |
|---|---|---|---|
| None | Reported | | |

Address:

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

**Specialty Board Certification(s)*:**

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

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

**Certifying Board:** TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
**Certificate:**
**Certificate Type:**

| Duration | Effective | Expiration | Reverification | Occurrence | Last Reported |
|---|---|---|---|---|---|

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



**Medicare/Medicaid Sanction(s):**

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

AMA AMERICAN MEDICAL ASSOCIATION

## AMA Physician Profile

**Other Federal Sanction(s):**

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

**Additional Information:**

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

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

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

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

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

# CASE WESTERN RESERVE UNIVERSITY

OFFICE OF THE REGISTRAR • CLEVELAND, OHIO 44106-7042 • registrar@cwru.edu

A BLACK AND WHITE TRANSCRIPT IS NOT OFFICIAL
TRANSCRIPT GUIDE PRINTED ON BACK

NOTE: TAMPERSAFE® AND HOLOGRAM CHANGES IMAGES WHEN VIEWED AT DIFFERENT ANGLES

TOUCH OR BREATHE ON TOUCHSAFE® FINGERPRINT TO VALIDATE

Student ID: 1013962
SSN: XXX-XX-6860
Student Name: Peggy Peng Ye

Official Transcript


11/23/2011
DOCID:1013991

Case Western Reserve University
University Registrar Office
This Transcript Was Issued In
A Sealed Envelope.

**Degrees Awarded**

Degree: DOCTOR OF MEDICINE
Confer Date: 05/18/2008

Plan: MEDICINE

**Beginning of Graduate/Professional Record**

**Fall 2004**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| CAPG C061 | BASIC SCIENCE CURRICULUM YR 1 | 7.00 | |
| CAPG 0603 | FUND OF MED DECISION-MAKING | 0.00 | |
| CAPG 0604 | BIOCHEMISTRY/CELL BIOLOGY | 0.00 | |
| CAPG 0605 | MOLECULAR BIO DEVEL & GENETICS | 0.00 | |
| CAPG 0606 | CELL PHYS/NEUROMUSC/MUSCSKELTL | 0.00 | |
| CAPG 0607 | CARDIOVASCULAR/PULMONARY | 0.00 | |
| CAPG 0637 | GROSS ANATOMY (LONGITUDINAL) | 0.00 | |
| CAPG 0638 | HISTOPATHOLOGY (LONGITUDINAL) | 0.00 | |
| CAPG 0691 | FOUNDATIONS OF CLIN MED YR 1 | 5.00 | |
| BIOC 3003 | BIOCHEMISTRY REVIEWS | 1.00 | |
| FAMD 2021 | ENERGY-BASED HEALING | 1.00 | |
| HEMA 3008 | WHAT CAUSES CANCER? | 1.00 | |

**Spring 2005**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| CAPG C061 | BASIC SCIENCE CURRICULUM YR 1 | 7.00 | |
| CAPG 0608 | RENAL/GI | 0.00 | |
| CAPG 0609 | ENDOCRINOLOGY/REPRODUCTIVE BIO | 0.00 | |
| CAPG 0610 | FUND OF THERAPEUTIC AGENTS | 0.00 | |
| CAPG 0611 | BIOLOGICAL BASIS OF DISEASE | 0.00 | |
| CAPG 0637 | GROSS ANATOMY (LONGITUDINAL) | 0.00 | |
| CAPG 0638 | HISTOPATHOLOGY (LONGITUDINAL) | 0.00 | |
| CAPG 0691 | FOUNDATIONS OF CLIN MED YR 1 | 5.00 | COM |
| ANAT 3003 | HEAD AND NECK GROSS ANATOMY | 1.00 | |
| FAMD 2011 | ALTERNATIVE MEDICINE II | 1.00 | |
| FAMD 2012 | ALTERNATIVE MEDICINE I | 1.00 | |
| FAMD 4010 | MANAGEMENT OF CHRONIC ILLNESS | 1.00 | |
| PEDS 4002 | MEDICAL HYPNOSIS | 1.00 | |

**Fall 2005**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| CAPG C062 | BASIC SCIENCE CURRICULUM YR 2 | 7.00 | |
| CAPG 0612 | HEMATOLOGY/ONCOLOGY | 0.00 | |
| CAPG 0613 | NERVOUS SYST/HEAD & NECK ANAT | 0.00 | |
| CAPG 0614 | THE MIND | 0.00 | |
| CAPG 0615 | MUSCULOSKELETAL INTEGUMENT | 0.00 | |
| CAPG 0616 | ENDOCRINOLOGY | 0.00 | |
| CAPG 0640 | PATHOLOGY (LONGITUDINAL) | 0.00 | |
| CAPG 0692 | FOUNDATIONS OF CLIN MED YR 2 | 5.00 | |

**Recipient:**

Peng Ye
[redacted]
USA

This official transcript is printed on light blue security paper and does not require a raised seal. The registrar's signature must appear below. See reverse side for transcript key and authenticity confirmation information.

Amy Hammett
University Registrar

TamperSafe®

TouchSafe®

Student ID: 1013962
SSN: XXX-XX-6860
Student Name: Peggy Peng Ye


Official Transcript



| Course | Description | Attempted | Grade |
|---|---|---|---|
| CLMI 6001 | MEDICAL APPRENTICESHIP | 1.00 | |
| DGMS 6003 | DAVID SATCHER LECTURE | 2.00 | |
| FAMD 5010 | DIFFERENTIAL DX IN FAM MED | 1.00 | |
| HLTH 5018 | HEALTHY BOYS AND GIRLS | 1.00 | |
| HLTH 5018 | HEALTHY BOYS AND GIRLS | 1.00 | |
| NEUM 5006 | NERVOUS SYSTEM CASE STUDIES | 1.00 | |

**Spring 2006**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| CAPG C062 | BASIC SCIENCE CURRICULUM YR 2 | 7.00 | |
| CAPG 0618 | CARDIOVASCULAR | 0.00 | |
| CAPG 0619 | PULMONARY | 0.00 | |
| CAPG 0620 | RENAL | 0.00 | |
| CAPG 0621 | GI/METABOLISM/NUTRITION | 0.00 | |
| CAPG 0622 | MECHANISMS OF INFECTION | 0.00 | |
| CAPG 0623 | DRUG ACTION AND BIODISPOSITION | 0.00 | |
| CAPG 0640 | PATHOLOGY (LONGITUDINAL) | 0.00 | |
| CAPG 0692 | FOUNDATIONS OF CLIN MED YR 2 | 8.00 | |
| CLMI 6001 | MEDICAL APPRENTICESHIP | 1.00 | |
| EMMD 6002 | INTRO TO EMERGENCY MEDICINE | 1.00 | |

**Fall 2006**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| CORE 0000 | BRIDGE TO CLERKSHIPS | 1.00 | |
| CORE 0211 | BASIC CORE I AT MHMC | 0.00 | |
| FAMC 0211 | FAMILY MEDICINE | 4.00 | |
| MEDC 0211 | MEDICINE AT MHMC | 6.00 | |
| SURC 0211 | SURGERY AT MHMC | 6.00 | |

**Spring 2007**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| ADVC 0204 | CARE OF OLDER ADULTS/AGING | 3.00 | |
| CORE 0122 | BASIC CORE II AT UH/VA | 0.00 | |
| NSCI 0122 | NEUROSCIENCE AT UH/VA | 3.50 | |
| OBGC 0122 | OB/GYN AT UH | 4.00 | |
| PEDC 0122 | PEDIATRICS AT UH | 5.00 | |
| PSYC 0122 | PSYCHIATRY AT UH/VA | 3.50 | |
| RADI 0193 | RADIOLOGY | 1.50 | |
| RBIO 0103 | OBSTETRICS ACTING INTERNSHIP | 3.00 | |
| UNEL 0002 | REPRODUCTIVE HLTH EXTERNSHIP | 1.50 | |

**Fall 2007**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| ADVC 0303 | CHRONIC DISEASE MANAGEMENT | 3.00 | |
| CLMI 0007 | CLINICAL SKILLS PRECEPTORSHIP | 3.00 | |
| CLMI 0203 | ACTING INTERNSHIP: MEDICINE | 3.00 | |
| HLTH 0002 | INTERNET HEALTH PROMOTION | 3.00 | |
| MISC 0096 | READINGS IN MEDICINE | 1.50 | |
| UNEL 0001 | FAMILY MEDICINE PRECEPTORSHIP | 3.00 | |

**Recipient:**

Peng Ye
[redacted]
USA

This official transcript is printed on light blue security paper and does not require a raised seal. The registrar's signature must appear below. See reverse side for transcript key and authenticity confirmation information.

Amy Hammett
University Registrar

NOTE: TAMPERSAFE® AND HOLOGRAM CHANGES IMAGES WHEN VIEWED AT DIFFERENT ANGLES

TOUCH OR BREATHE ON TOUCHSAFE® FINGERPRINT TO VALIDATE

TamperSafe®

TouchSafe®

# CASE WESTERN RESERVE UNIVERSITY

OFFICE OF THE REGISTRAR • CLEVELAND, OHIO 44106-7042 • registrar@cwru.edu

A BLACK AND WHITE TRANSCRIPT IS NOT OFFICIAL
TRANSCRIPT GUIDE PRINTED ON BACK

NOTE: TAMPERSAFE® AND HOLOGRAM CHANGES IMAGES WHEN VIEWED AT DIFFERENT ANGLES

TOUCH OR BREATHE ON TOUCHSAFE® FINGERPRINT TO VALIDATE



**Spring 2008**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| ADVC 0202 | PERI-OPERATIVE CARE/PAIN MGMT | 3.00 | |
| ADVC 0301 | EMERGENCY/UNDIFFERENTIATED CR | 3.00 | |
| MISC 0006 | READINGS IN MEDICINE | 3.00 | |
| PATH 0192 | SURGICAL PATHOLOGY | 1.50 | |
| UNEL 0001 | MATERNAL CHILD HEALTH | 3.00 | |

**End of Graduate/Professional Record**
**End of Transcript**

**Recipient:**

Peng Ye
[redacted]
USA

This official transcript is printed on light blue security paper and does not require a raised seal. The registrar's signature must appear below. See reverse side for transcript key and authenticity confirmation information.

Amy Hammett
University Registrar

TamperSafe®

TouchSafe®

# CASE WESTERN RESERVE UNIVERSITY

OFFICE OF THE REGISTRAR • CLEVELAND, OHIO 44106-7042 • registrar@cwru.edu

A BLACK AND WHITE TRANSCRIPT IS NOT OFFICIAL
TRANSCRIPT GUIDE PRINTED ON BACK

NOTE: TAMPERSAFE® AND HOLOGRAM CHANGES IMAGES WHEN VIEWED AT DIFFERENT ANGLES

TOUCH OR BREATHE ON TOUCHSAFE® FINGERPRINT TO VALIDATE

**Student ID:** 1013962
**SSN:** [redacted]
**Student Name:** Peggy Peng Ye

**Official Transcript**


11/23/2011
DOCID:1013991

Case Western Reserve University
University Registrar Office
This Transcript Was Issued In
A Sealed Envelope

**Degrees Awarded**

Degree: BACHELOR OF SCIENCE
Confer Date: 05/16/2004

Degree Honors: SUMMA CUM LAUDE
Plan: BIOLOGY

**Academic Program History**

Program: ASIAN STUDIES - (Minor)

**Test Credits**

ADVANCED PLACEMENT CREDIT Applied Toward UNDERGRADUATE Record

*2001 FALL*

| Course | Description | Attempted | Earned | Grade | Points |
|---|---|---|---|---|---|
| BIOL 110 | PRINCIPLES OF BIOLOGY | | 3.00 | | |
| BIOL 111 | INTRO TO EXPER BIOLOGY LAB | | 2.00 | | |
| CHEM 105 | PRINCIPLES OF CHEMISTRY I | | 3.00 | | |
| CHEM 106 | PRINCIPLES OF CHEMISTRY II | | 3.00 | | |
| CHEM 113 | PRINCIPLES OF CHEMISTRY LAB | | 2.00 | | |
| ENGL 150 | EXPOSITORY WRITING | | 3.00 | | |
| MATH 121 | CALC FOR SCIENCE & ENGR I | | 4.00 | | |
| MATH 122 | CALC FOR SCIENCE & ENGR II | | 4.00 | | |
| Course Trans GPA: 0.00 | Transfer Totals: | 0.00 | 24.00 | | 0.000 |

**Transfer Credits**

**Transfer Credit From: OHIO STATE UNIV**
Applied Toward UNDERGRADUATE
**Earned Credits: 9.99**

COMPLETED SECOND MINOR IN CHEMISTRY

**Beginning of Undergraduate Record**

**Fall 2000**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| BIOL 210 | MOLECULAR CELL BIOLOGY | 4.00 | |
| CLSC 201 | THE ANCIENT WORLD | 3.00 | |
| FRCH 201 | INTERMEDIATE FRENCH I | 4.00 | |
| MATH 223 | CALC FOR SCIENCE & ENGR III | 3.00 | |
| STAT 201 | BAS STAT SOC SCI & LIFE SCI | 3.00 | |

DEAN'S HIGH HONORS 12/28/00

| | | Attempted | Earned | Averaged | Points |
|---|---|---|---|---|---|
| Term GPA: [redacted] | Term Totals | 17.00 | 17.00 | 17.00 | [redacted] |

**Spring 2001**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| BIOL 326 | GENETICS | 3.00 | |
| CHIN 202 | INTERMEDIATE CHINESE II | 4.00 | |

**Recipient:**

Peng Ye
[redacted]
USA

This official transcript is printed on light blue security paper and does not require a raised seal. The registrar's signature must appear below. See reverse side for transcript key and authenticity confirmation information.

Amy Hammett
University Registrar

TamperSafe®

TouchSafe®

NOTE: TAMPERSAFE® AND HOLOGRAM CHANGES IMAGES WHEN VIEWED AT DIFFERENT ANGLES

TOUCH OR BREATHE ON TOUCHSAFE® FINGERPRINT TO VALIDATE

Student ID: 1013962
SSN: XXX-XX-6860
Student Name: Peggy Peng Ye

Official Transcript


11/23/2011
DOCID:1013991

| Course | Description | Attempted | Grade |
|---|---|---|---|
| ECON 103 | PRIN OF MACROECONOMICS | 3.00 | |
| ENGR 131 | ELEMENTARY COMPUTER PROG | 3.00 | |
| FRCH 202 | INTERMEDIATE FRENCH II | 4.00 | |
| PHED 119 | SKIN & SCUBA | 0.00 | |

DEAN'S HIGH HONORS 05/14/01

| | Attempted | Earned | Averaged | Points |
|---|---|---|---|---|
| Term GPA: Term Totals | 17.00 | 17.00 | 17.00 | |

**Fall 2001**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| ARTH 101 | ART HISTORY I | 3.00 | |
| BIOL 211 | LAB IN BIOCHEM MOLEC/CELL BIOL | 2.00 | |
| CHEM 223 | INTRO TO ORGANIC CHEMISTRY I | 3.00 | |
| CHEM 233 | INTRO ORGANIC CHEMISTRY LAB I | 2.00 | |
| CHIN 301 | ADVANCED CHINESE I | 4.00 | |
| PHED 031A | TENNIS (1ST HALF) | 0.00 | |
| SOCI 204 | CRIMINOLOGY | 3.00 | |

| | Attempted | Earned | Averaged | Points |
|---|---|---|---|---|
| Term GPA: Term Totals | 17.00 | 17.00 | 17.00 | |

**Spring 2002**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| ASIA 133 | INTRO TO CHINESE HISTORY | 3.00 | |
| BIOL 216 | ORGANISMS AND ECOSYSTEMS | 4.00 | |
| BIOL 388 | UNDERGRADUATE RESEARCH | 3.00 | |
| CHEM 224 | INTRO TO ORGANIC CHEMISTRY II | 3.00 | |
| CHEM 234 | INTR ORGANIC CHEMISTRY LAB II | 2.00 | |
| STAT 312 | STATISTICS FOR ENG AND SCIENCE | 3.00 | |

DEAN'S HIGH HONORS 05/13/02

| | Attempted | Earned | Averaged | Points |
|---|---|---|---|---|
| Term GPA: Term Totals | 18.00 | 18.00 | 18.00 | |

**Fall 2002**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| BIOL 301 | BIOTECH LAB:GENES/GENET ENGR | 3.00 | |
| BIOL 310 | POP BIOL:BEHAV, ECOL, GENETICS | 3.00 | |
| BIOL 390 | ADV UNDERGRADUATE RESEARCH | 3.00 | |
| PHYS 115 | INTRODUCTORY PHYSICS I | 4.00 | |
| POSC 368 | THE PEOPLE'S REPUBLIC OF CHINA | 3.00 | |

| | Attempted | Earned | Averaged | Points |
|---|---|---|---|---|
| Term GPA: Term Totals | 16.00 | 16.00 | 13.00 | |

**Spring 2003**

| Course | Description | Attempted | Grade |
|---|---|---|---|
| BIOL 205 | CHEMICAL BIOLOGY | 3.00 | |
| BIOL 308 | MOL BIOL:GENES & GENETIC ENGR | 4.00 | |
| BIOL 382 | DRUGS, BRAIN, AND BEHAVIOR | 3.00 | |
| BIOL 395 | RESEARCH DISCUSSIONS | 1.00 | |

**Recipient:**

Peng Ye
[redacted]
USA

This official transcript is printed on light blue security paper and does not require a raised seal. The registrar's signature must appear below. See reverse side for transcript key and authenticity confirmation information.

Amy Hammett
University Registrar

TamperSafe®

TouchSafe®

# CASE WESTERN RESERVE UNIVERSITY

OFFICE OF THE REGISTRAR • CLEVELAND, OHIO 44106-7042 • registrar@cwru.edu

A BLACK AND WHITE TRANSCRIPT IS NOT OFFICIAL
TRANSCRIPT GUIDE PRINTED ON BACK



Student ID: 1013962
SSN: XXX-XX-6860
Student Name: Peggy Peng Ye

Official Transcript

| Course | Description | Attempted | Grade |
|---|---|---|---|
| PHYS 116 | INTRODUCTORY PHYSICS II | 4.00 | |
| SOCI 112B | INTR SOCI: HUMAN INTERACTION | 3.00 | |

DEAN'S HIGH HONORS 05/13/03

| | Attempted | Earned | Averaged | Points |
|---|---|---|---|---|
| Term GPA: Term Totals | 18.00 | 18.00 | 17.00 | |

Fall 2003

| Course | Description | Attempted | Grade |
|---|---|---|---|
| ASIA 230 | ASIAN CINEMA AND DRAMA | 3.00 | |
| ASTR 188 | ON BEING A SCIENTIST | 1.00 | |
| BIOL 313 | GENETICS LABORATORY | 2.00 | |
| BIOL 346 | HUMAN ANATOMY | 3.00 | |
| CHEM 301 | INTRO PHYSICAL CHEMISTRY I | 3.00 | |
| ENGL 268 | UNDERSTANDING MOVIES | 3.00 | |
| HSTY 284 | DAILY LIFE IN IMPERIAL CHINA | 3.00 | |

DEAN'S HIGH HONORS 12/22/03

| | Attempted | Earned | Averaged | Points |
|---|---|---|---|---|
| Term GPA: Term Totals | 18.00 | 18.00 | 17.00 | |

Spring 2004

| Course | Description | Attempted | Grade |
|---|---|---|---|
| BIOL 315 | QUANTITATIVE BIOLOGY LAB | 3.00 | |
| CLSC 295A | BASIC GREEK & LATIN ELEMENTS | 1.50 | |
| CLSC 295B | ADV ELEMNTS:BIOMED TERMINOLOGY | 1.50 | |
| CLSC 305 | STORY & HSTY IN ANCIENT WORLD | 3.00 | |
| CMPL 215 | JAPANESE POPULAR CULTURE | 3.00 | |
| PHED 017B | DANCE AEROBICS (2ND HALF) | 0.00 | |

DEAN'S HIGH HONORS 05/10/04

| | Attempted | Earned | Averaged | Points |
|---|---|---|---|---|
| Term GPA: Term Totals | 12.00 | 12.00 | 9.00 | |

| | Attempted | Earned | Averaged | Points |
|---|---|---|---|---|
| Career Totals<br>Cum GPA: Cum Totals | 133.00 | 133.00 | 125.00 | |

Total Credits Earned: 166.99

End of Undergraduate Record

Recipient:

Peng Ye
[redacted]
USA

This official transcript is printed on light blue security paper and does not require a raised seal. The registrar's signature must appear below. See reverse side for transcript key and authenticity confirmation information.

Amy Hammett
University Registrar

TamperSafe®

TouchSafe®

TOUCH OR BREATHE ON TOUCHSAFE® FINGERPRINT TO VALIDATE

Brad A. Myers
University Registrar

Name : Peng Ye
Student ID: 100637583
Birth MO/DAY : [redacted]
Print Date: 12/14/2011
Page 1 of 1
STUOF-ISSUED TO STUDENT

**PENG YE**

[redacted]

----- Beginning of Undergraduate Record -----

Autumn 1999 Quarter

Program : Academy
Plan : The Ohio State Academy Program Course of Study

| Course | Description | Attempted | Earned | Grade | Points |
|---|---|---|---|---|---|
| PSYCH 100 | General Psychology | 5.00 | 5.00 | [redacted] | 20.000 |
| Test Credits Applied Toward Academy Program | | | | | |
| MATH 150 | Elementry Functns | 5.00 | 5.00 | [redacted] | |
| Test Trans GPA: 0.000 | Trns Total: | 5.00 | 5.00 | | 0.000 |
| TERM GPA : [redacted] | TERM TOTALS : | 5.00 | 5.00 | | 20.000 |
| CUM GPA : [redacted] | CUM TOTALS : | 5.00 | 10.00 | | 20.000 |

Winter 2000 Quarter

Program : Academy
Plan : The Ohio State Academy Program Course of Study

| Course | Description | Attempted | Earned | Grade | Points |
|---|---|---|---|---|---|
| ECON 200 | Prin Microeconomic | 5.00 | 5.00 | [redacted] | 20.000 |
| TERM GPA : [redacted] | TERM TOTALS : | 5.00 | 5.00 | | 20.000 |
| CUM GPA : [redacted] | CUM TOTALS : | 10.00 | 15.00 | | 40.000 |

Spring 2000 Quarter

Program : Academy
Plan : The Ohio State Academy Program Course of Study

| Course | Description | Attempted | Earned | Grade | Points |
|---|---|---|---|---|---|
| PHILOS 130 | Intro To Ethics | 5.00 | 5.00 | [redacted] | 20.000 |
| TERM GPA : [redacted] | TERM TOTALS : | 5.00 | 5.00 | | 20.000 |
| CUM GPA : [redacted] | CUM TOTALS : | 15.00 | 20.00 | | 60.000 |

*Part Time Dean's List*

Undergraduate Career Totals

| | | | | | |
|---|---|---|---|---|---|
| CUM GPA : [redacted] | CUM TOTALS : | 15.00 | 20.00 | | 60.000 |

----- End of Transcript -----

THE OHIO STATE UNIVERSITY TRANSCRIPT

THE OHIO STATE UNIVERSITY TRANSCRIPT

2476873

TRANSLUCENT GLOBES MUST BE VISIBLE FROM BOTH SIDES
OF TRANSCRIPT WHEN HELD TOWARD LIGHT SOURCE

THE UNIVERSITY SEAL APPEARS IN WHITE POINT ACROSS THE FACE OF THIS RECORD

University Hospitals
MacDonald Women's Hospital

SCHOOL OF MEDICINE
CASE WESTERN RESERVE UNIVERSITY

**Obstetrics & Gynecology**
11100 Euclid Avenue
MAC 5034
Cleveland, OH 44106-5034

Nancy J Cossler, MD
Director, Resident Education, Obstetrics & Gynecology

Vice Chair, Quality and Patient Safety
MacDonald Women's Hospital
University Hospitals Case Medical Center
Case Western Reserve University Cleveland Ohio
Phone: 216/844-8551 Fax: 216/844-3348 E-mail: nancy.cossler@uhhospitals.org

December 12, 2011

Re: Peng (Peggy) Ye, M.D.

To Whom It May Concern:

This letter is to verify that Dr. Peggy Ye is currently a chief resident in the department of Obstetrics and Gynecology at University Hospitals Case Medical Center.

Dr. Ye began her residency training in our program on June 24th 2008. She is expected to complete her training and graduate from our residency program on June 30th 2012.

If you require additional information, please don't hesitate to call me at 216-844-8551.

Sincerely,

Nancy J. Cossler, M.D.
Director, Resident Education, Obstetrics and Gynecology

Vice Chair, Quality and Patient Safety
Mac Donald Women's Hospital
University Hospitals Case Medical Center

NJC/jl

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

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

Date : 01/11/2012

Recipient:

District of Columbia Board of Medicine
ATTN: Antoniette Stokes
899 North Capitol St NE
1st Floor
Washington, DC 20002

Examinee: Ye, Peng
Alt Name(s):

Examinee ID#: 5-180-252-8
Date of Birth:

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

## USMLE STEP 1

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments |
| | 06/30/2006 | Pass | | | | | |

## USMLE STEP 2

**Clinical Knowledge (CK)**

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments |
| | 10/12/2007 | Pass | | | | | |

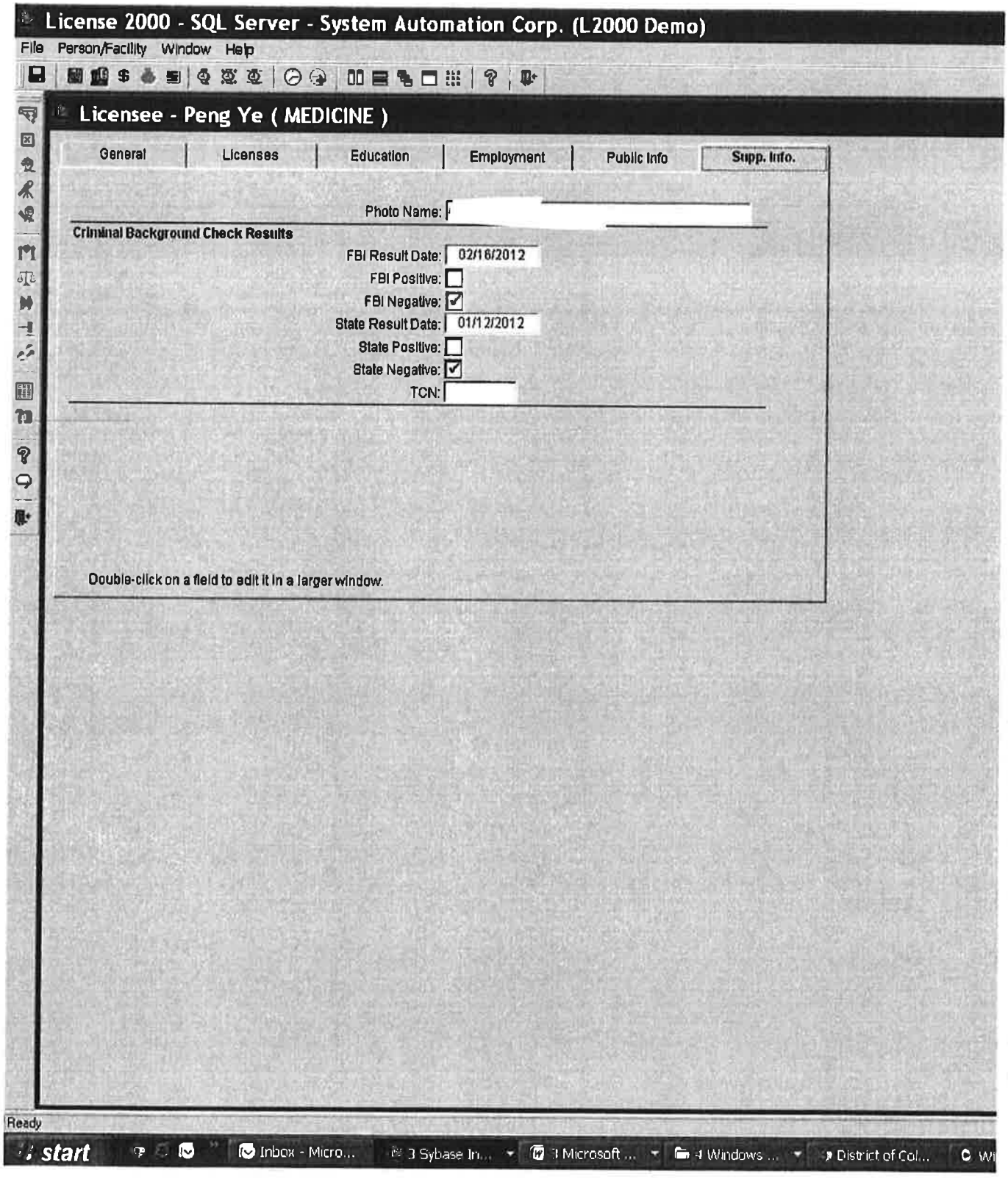
**Clinical Skills (CS)***

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments |
| | 10/18/2007 | Pass | | | | | |

## USMLE STEP 3

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments |
| OHIO | 04/06/2010 | Pass | | | | | |

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


License 2000 - SQL Server - System Automation Corp. (L2000 Demo)
File Person/Facility Window Help
Licensee - Peng Ye ( MEDICINE )
General
Licenses
Education
Employment
Public Info
Supp. Info.
Photo Name:
Criminal Background Check Results
FBI Result Date: 02/16/2012
FBI Positive:
FBI Negative:
State Result Date: 01/12/2012
State Positive:
State Negative:
TCN:
Double-click on a field to edit it in a larger window.
Ready
start
Inbox - Micro...
3 Sybase In...
3 Microsoft ...
4 Windows ...
District of Col...

# REQUEST FOR LOCAL RECORD CHECK

DATE OF REQUEST: 12/20/11 TIME: 09:10

NAME: PENG YE

MAIDEN and/or ADDITIONAL NAMES: PEGGY PENG YE

PRESENT ADDRESS: [redacted]

TELEPHONE NUMBER(S): [redacted]

DATE OF BIRTH: [redacted] SS #: [redacted]

COMPLETE NAME AND ADDRESS OF COMPANY/ORGANIZATION REQUIRING RECORD CHECK: (send copy to address below)

NAME: Cleveland Heights Police Department, Chief's Office

ADDRESS: 40 SEVERANCE CIRCLE, CLEVELAND HEIGHTS, OH 444118

Signature of person making request: [signature]

Cleveland Heights Police Department
Detective Bureau
No Criminal Record
Local Record Check Only

Date 12 2011

Signature [signature]

Mike DeWine
Ohio Attorney General

BCI - Identification
Office: 877-224-0043
Fax: 740-845-2633

P.O. Box 365
London, OH 43140
www.ohioattorneygeneral.gov

December 21, 2011

PENG YE

**NO BCI&I RECORD ON FILE**
**AUTHENTICATION NO. CS0102411CK91948**

The Ohio Bureau of Criminal Identification and Investigation (BCI&I) has completed a criminal history record check on the applicant listed below. Based upon information furnished by your agency, BCI&I has **NO CRIMINAL HISTORY RECORD** on file for:

| | |
|---|---|
| **Name:** | **YE, PENG** |
| **Date of Birth:** | |
| **SSN:** | |
| **Date Completed:** | **December 20, 2011** |
| **Reason Fingerprinted:** | **Other** |

This "No Record" verification is valid for one year from the record check completion date. This letter may be photocopied by the prospective employer and retained by the applicant.

Thomas J. Stickrath, Superintendent
Ohio Bureau of Criminal
Identification and Investigation

2PN431

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

# BOARD ACTION CLEARANCE REPORT

January 10, 2012

District of Columbia Board of Medicine
Attn: Jacqueline A. Watson, DO, MBA
899 North Capitol Street, NE
First Floor
Washington, DC 20002

Re: Board Action Query Dated: January 10, 2012
Your Reference Number:
FSMB Batch Number: BQ2012969

The following is a report of the search results from the Board Action Data Bank as of January 10, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of January 10, 2012

| Name | DOB | School | Yr/Grad | Request ID |
|---|---|---|---|---|
| [redacted] | [redacted] | [redacted] | [redacted] | |
| Ye, Peng | | 036010 | 2008 | 24722373 |

**LICENSE HISTORY**
State Board
OHIO

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

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**DEPARTMENT OF HEALTH**
**HEALTH PROFESSIONAL LICENSING ADMINISTRATION**
***BOARD OF MEDICINE***
***899NorthCapitolStreet,NE,FirstFloor***
***Washington DC 20002***

**DISCIPLINARY INQUIRIES**
Federation of State Medical Boards
400 Fuller-Wise Road
Suite 300
Euless, Texas 76039-3855

*The District of Columbia Board of Medicine requests a disciplinary search concerning the following individual:*

Ye, Peng
***Name (Last, First, Middle)***

***DATE OF BIRTH (month/day/year)*** ***Social Security Number***

***License No.***

11100 Euclid Ave.
***Street Address (Business)*** ***(Apt. #)***

Cleveland, OH 44106
***City, State, Zip Code***

Case Western Reserve University 5/18/08
***Medical School of Graduation and Branch Location*** ***Date of Graduation***

*Please mail the response to the following address:*
**Department of Health**
**D.C. Board of Medicine**
899 North Capitol Street, NE, First Floor
Washington DC 20002

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

JAN 10 2012

Humayun J. Chaudhry, D.O., FACP
President and CEO

Peng Ye, MD 040333

New Applicant 2/7/12

ENTERED 4/10/2012

Change Name

**Government of the District of Columbia**

**Department of Health**
**Health Professionals**
**Licensing Administration**

**D.C. Board of Medicine**
**Physician Profile**

Please correct and initial any provided information that is inaccurate by drawing a line through the incorrect item and printing in ink the correction above or next to the incorrect item. Please type or print (legibly) any information that is not provided.

**Please check this box if you are interested in volunteering for medical response during a bioterrorism event or any other public health emergency (Optional).**

## 1. General Information:

Initial License Date _____ License Expiration Date _____

**Maiden Name *(Optional)*:** _____

Include maiden name in profile? *(Check one)* Yes No

*NOTE: The information prepopulated above cannot be changed by the practitioner. If you have a name change, notify the Board in writing and include legal documentation that supports the change.*

## 2. Emergency Contact Information:

**Web Site *(Optional)*:** _____

Include website address in profile? *(Check one)* Yes No

**E-mail Address *(Optional*** _____

Include email address in profile? *(Check one)* Yes (No)

*NOTE: Please provide a non-emergency e-mail address if you wish to communicate with the Board of Medicine electronically in the future.*

**Fax Number:** _____

Check this box if you do not have a fax number.

**Security Verification *(Optional):*** _____ _____

*NOTE: If you provided a non-emergency e-mail address above, for verification purpose, please provide mother maiden name. This will facilitate electronic retrieval of a forgotten password in the future.*

**Mother's maiden name:** _____

## 3. Address of Record:

(Used to receive license renewals, notifications, and orders)

_____

_____ _____

_____

**4. Do you have primary Practice Address?** (Yes) No

Practice Name *(Optional)* Washington Hospital Center
Address *(Line 1)* 110 Irving St NW
Address *(Line 2)* _____
City Washington
State DC
Zip code 20010
Telephone (___)_____

**% Time spent at this location** 100 %
Translating Services available? *(check one)* (Yes) No

| *If yes, please check type (s) of translating services that are available:* |
|---|
| X Hearing impaired<br>X Non-English languages spoken |

Non-English Languages Spoken *(attach additional sheets if necessary)*.

_____ _____ _____ _____ _____ _____ _____

Non-English Languages Spoken by Practitioner. *(attach additional sheets if necessary).*

_____ _____ _____ _____ _____ _____

Days patients seen at this location (i.e. M-W-,F) *(Optional)* _____

**5. Do you have an Additional Practice Address?** Yes (No)
(attach additional sheets if necessary)

Practice Name *(Optional)* _____
Address *(Line 1)* _____
Address *(Line 2)* _____
City _____
State _____
Zip code _____
Telephone (___)_____

**% Time spent at this location** _____ %
Translating Services available? *(check one)* Yes No

| *If yes, please check type (s) of translating services that are available:* |
|---|
| Hearing impaired<br>Non-English languages spoken |

Non-English Languages Spoken *(attach additional sheets if necessary).*

_____ _____ _____ _____ _____ _____

Non-English Languages Spoken by Practitioner *(attach additional sheets if necessary).*

_____ _____ _____ _____ _____ _____

Days patients seen at this location M-W, F):*(Optional)* _____

**6. Education:** Please select the U.S. or Canadian school **Osteopathic,** attended *(attach additional sheets if necessary).*

U.S. or Canadian School Attended Case Western Reserve University
U.S. or Canadian School Year of completion 2008 (Allopathic)

If you attended a **non-U.S.** (and territories) **non-Canadian** school, please enter the name of the school below:

Non-U.S. School Attended _____
Non-U.S. Year of completion Non-U.S. State or Province _____
Non-U.S. Country _____

**7. Post Graduate**: Please indicate the name of the postgraduate medical or osteopathic education program attended (attach additional sheets if necessary):

Specialty Obstetrics + Gynecology
Program Name University Hospitals case medical center
City Cleveland State/Province OH Country USA
Years Attended 2008 - 2012
Internship (Residency) Fellowship

Specialty _____
Program Name _____
City _____ State/Province _____ Country _____
Years Attended _____
Internship Residency Fellowship

Specialty _____
Program Name _____
City _____ State/Province _____ Country _____
Years Attended _____
Internship Residency Fellowship

**8. Board Certification:** Are you currently Board certified or sub-certified as approved by American Board of Medical Specialties or the Bureau of Osteopathic Specialists of the American Osteopathic Association? Yes (No)

If yes, please indicate the initial year of certification/ certification, and the year of expiration *(attach additional sheets if necessary).*

Year of Certification _____ Year of Expiration _____

Year of Certification _____ Year of Expiration _____

Year of Certification _____ Year of Expiration _____

**9. Self-Designated Practice Area:** Please indicate designated areas of practice (attach additional sheets if necessary):

Obstetrics Gynecology Family planning

**10. Active/Clinical Practice:** Please indicate total number of years in practice following completion of graduate medical, osteopathic, or education:

Number of years in active/clinical practice inside U.S./Canada Territories: 8

Number of years in active/clinical practice outside U.S./Canada Territories: 8

**11. Medicaid:**

Do you participate in District of Columbia Medicaid program? (check one) (Yes) No

Are you accepting new District of Columbia Medicaid patients? (check one) (Yes) No

**12. Medicare:**

Are you a Medicare participating provider? (check one) (Yes) No

Are you a Medicare non-participating provider? (Optional) (check one) (Yes) No

Are you accepting new Medicare patients? (Optional) (check one) (Yes) No

**13. Current District of Columbia Hospitals with Admitting Privileges:**

Please indicate from all the District of Columbia hospital/facilities at which you have admitting privileges (attach additional sheets if necessary).

none - will be at Washington Hospital Center starting 7/2012

**14. Current District of Columbia Hospital Affiliations:** Please indicate from any other District of Columbia hospital privileges/affiliated (attached additional sheets if necessary).

none - see above

**15. Current Out-of-State Hospital Affiliations:** Please list the hospital name, city, and state for all hospitals privileges/affiliations in all states other than the District of Columbia (attached additional sheets if necessary).

Hospital University Hospitals Case Medical Center City Cleveland State OH

Hospital _____ City _____ State _____

**16. Do you wish to provide information on Insurance Plans/Managed Care Plans Accepted *(Optional)*?** Yes (No)

If yes, please list up to 10 health insurance plans that you accept. Include the name of the insurance company and the name of the specific insurance plan or managed care plan for each entry( e.g., Blue Cross and Blue Shield"). Check the box to the right of each entry if you also are a participating provider of the plan.

| | Name of Insurance or Managed Care Plan Accepted | I am a participating provider in this plan |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |

Please provide a contact telephone number that consumers can call for further information on Insurance Plans that you accept: (_____)_____.

**17. US/Canada Academic Appointments:** Please indicate U.S./Canada Territories academic appointments *(attach additional sheets if necessary)*.

School _____ Years Service _____to_____
School _____ Years Service _____to_____
School _____ Years Service _____to_____

**18. Non-U.S./Canada Academic Appointments:** Please list non-U.S/Canada Territories academic appointments. Provide the full name and country for the school *(attach additional sheets if necessary):*

| School | Country | Years of Service |
|---|---|---|
| _____ | _____ | _____ to_____ |
| _____ | _____ | _____ to_____ |
| _____ | _____ | _____ to_____ |

**19. Publications:** Please list publications in peer-reviewed literature within the last five years (maximum) of ten articles, attach additional sheets if necessary):

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

**20. Honors/Awards *(Optional)*:** If you wish to provide information on honors or awards received, please indicate in the space provided. You may also use this section to include board certifications that are not listed in the Board Certification section (attach additional sheets if necessary).

Name of Honor/Award _____
Received From _____
Year Received _____

Name of Honor/Award _____
Received From _____
Year Received _____

## 21. District of Columbia Board of Medicine Notices and Orders:

Have you been the subject of a District of Columbia Board of Medicine Public Order.

Yes:_____ No: X

**22. Actions 1:** You are required to report the following actions:

- Final orders of any regulatory board of another jurisdiction that result in the denial, probation, revocation, suspension, or restriction of any license;

- Final orders of any health regulatory board of another jurisdiction that result in reprimand or censure;
- Voluntary surrender of a license while under investigation in a state other than District of Columbia;
- Any disciplinary action taken by a federal health institution or federal agency.

Do you have any reportable actions? (check one) Yes (No)

*NOTE:* If yes, please complete the sections below (attach additional sheets if necessary):

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

**23. Actions 2:** Have you ever had any action taken by healthcare institutions, other practitioners, insurance companies, health maintenance organizations or professional organizations that resulted in a suspension or revocation of privileges or the of employment? *(check one)* Yes (No)

*NOTE:* If yes, please complete the sections below *(attach additional sheets if necessary):*

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

**24. Paid Claims:** You are required to provide a complete listing of all paid claims for the last ten years. This should include paid claims not only in the District of Columbia, but in other states and countries as well. Print the city, use the two letter state abbreviation, and print the country if non-U.S. For each paid claim, you may submit a brief description of the case for consumers to view. The presentation of this text will be limited to 300 characters on the web site. Please provide this text on an additional sheet of paper.

Payment Year: _____
Total US Dollar Amount: _____
Code for the Specialty at the time of paid claim: _____
City/State and/or Country _____
Settlement:_____ Judgment:_____

Payment Year: _____
Total US Dollar Amount: _____
Code for the Specialty at the time of paid claim: _____
City/State and/or Country _____
Settlement:_____ Judgment:_____

Payment Year: _____
Total US Dollar Amount: _____
Code for the Specialty at the time of paid claim: _____
City/State and/or Country _____
Settlement:_____ Judgment:_____

**25. Felony Conviction Information:** Have you ever been convicted in a court of law of committing a felony? *(check one)*

Yes
(No)

***NOTE: If yes, please complete all of the sections below (attach additional sheets).***

Date of conviction MM/DD/YYYY __/__/____

Were you convicted in the U.S. of a federal or state offense? *(check one)*

1. Federal State:
2. State - ***specify which state:***_____
3. No-I was convicted of an offense in a non-U.S. country

Please specify U.S. state or federal code section (alpha numeric designation) that defines offense committed (do not complete if offense was committed in non-U.S. country): _____

Please provide a written description of the type of offense that was committed:

_____
_____
_____
_____

Please specify the jurisdiction where conviction occurred:
City/State and/or Country (if non-U.S.): _____

Type of sentence received (check only one):

1) Incarceration followed by probation
2) Incarceration without probation
3) Active supervised probation only
4) Active unsupervised probation only

Date of sentencing MM/DD/YYYY __/__/____

Length of sentence:

1. Suspended sentence: Number of years_____ Number of months_____
2. Sentence served: Number of years_____ Number of Months_____

## Attestation:

I certify that the information provided in this questionnaire is true, complete, and accurate to the best of my knowledge. I further understand that providing incomplete or false information may constitute unprofessional conduct and may subject me to disciplinary action by the District of Columbia Board of Medicine.

District Of Columbia Board of Medicine Regulation **17 DCMR 4609** requires that I update my information within thirty days of a change.

**Print Name** Peng Ye

**Signature** 

**Complete License number** _____

**Date** 12/20/11

Thank you for completing your questionnaire. You do not need to return the Code Lists, By regulation, your information must be received by the Board within **30** days from the date of the initial request. Earlier submission will expedite the Practitioner Information Collection process and would be most appreciated.

Please mail your completed and signed questionnaire to:

District of Columbia Board of Medicine Practitioner Information

899 North Capitol Street, NE, First Floor
Washington, DC 20002
If you have any questions, please call at:
(202) 724-4900

To view or edit your public profile online, visit the consumer website:

www.hpla.doh.dc.gov

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE


# Medical Professional Information Profile

*This report provides credentialing information for*

Name: **Peng Ye**

Social Security: Number:

Date of Birth:

FID#: **215294000**

Recipient: **DC - District of Columbia Board of Medicine**

## 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.



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



2/16/12 CA

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: **Peng Ye**
Date of Birth:
Social Security Number:
FID: **215294000**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Valid Original Passport

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

Case Western Reserve University School of Medicine

1. Medical Education Form
2. Medical Education L2
3. Medical Education Dean's Letter
4. Medical Education Transcript
5. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Case Western Reserve Univ - University Hospitals of Clevelan

1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

A. FSMB Exams

End of report for: Peng Ye

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

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

# Medical Professional Profile

Federation of STATE MEDICAL BOARDS

## Table of Contents




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

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

**Medical Professional Information Profile**

Federation of STATE MEDICAL BOARDS

# Section I

## FCVS Reports

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

## Identity

Medical Professional Name: **Peng Ye**
Documentation: Valid Original Passport

Variation of Name: **Peggy Peng Ye**
Explanation: Informal name used on some official documents.

Gender: Female

Date of Birth:

Place of Birth

Social Security Number:

FID: 215294000

Physical Description: Height:
Weight:
Eye Color:
Hair Color:

## Contact Information

Mailing Address:

UNITED STATES

Permanent Address:

UNITED STATES

Telephone Numbers: Primary:
Secondary: N/A
Fax: N/A
Other: N/A

## Premedical Education

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

**Institution:** **Case Western Reserve University**
Address: Cleveland, OH 44106-7042
UNITED STATES
Dates of Attendance: 08/--/2000 To 05/--/2004
Degree Conferred/Issued: Bachelor of Science

## ECFMG

There are none identified or not applicable.

## Medical Education

**Medical School:** **Case Western Reserve University School of Medicine**
Address: Office of the Registrar, T-408
10900 Euclid Avenue
Cleveland, OH 44106-4968
UNITED STATES

Dates of Attendance: 08/05/2004 to 05/18/2008
Date Certificate Issued: 05/18/2008
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:** **Case Western Reserve Univ - University Hospitals o**
Address: 11100 Euclid Avenue

Cleveland, OH 44106
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/24/2008 To 06/24/2009
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2 - 3
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/24/2009 To 06/24/2011
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 4
Program Type: Chief Resident
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/24/2011 To 06/30/2012
Completed Successfully: In Progress
Accreditation: ACGME

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

## Licensure Examinations

There are none identified or not applicable.

## 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 Peng Ye FID: 215294000**

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, PGT 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: **Peng Ye**

Date of Birth:

Social Security Number:

FID: **215294000**

## Omissions

There are no omissions identified.

## Discrepancies

There are no discrepancies identified.

## Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Peng Ye

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

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: **Peng Ye**
Date of Birth: **July 16, 1982**
Social Security Number: **XXX-XX-6860**
FID#: **215294000**

| Start Date | End Date | Activity | Location | Overlap Explanation | Program Length Explanation |
|---|---|---|---|---|---|
| 7/2004 | 05/2008 | Medical Education Record | Case Western Reserve University School of Medicine,Office of the Registrar, T-408 Cleveland, OH 44106-4968 UNITED STATES | | |
| 6/2008 | 06/2012 | GME Record | Case Western Reserve Univ - University Hospitals o,11100 Euclid Avenue Cleveland, OH 44106 UNITED STATES | | |

End of report for Peng Ye

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

# Section II

## FSMB and Other Reports

400 FULLER WISER ROAD | SUITE 700 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FPDC FEDERATION PHYSICIAN DATA CENTER

**Board Action Clearance Report**

February 07, 2012

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

Re: Board Action Query Dated: February 07, 2012
FSMB Batch Number: BQ2026623

The following is a report of the search results from the Board Action Data Bank as of February 07, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of February 07, 2012

| Name | DOB | School | Yr/Grad | Provider ID |
|---|---|---|---|---|
| Peng Ye | | 036010 | 2008 | 222308 |

**License History**

Licensing Entity
OHIO

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

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

# Section III

## Identity

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

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 read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to 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:**
**The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.**

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.

While the FSMB will only use collected personal information for the purposes described on our website and in the FCVS application materials, the FSMB has no control over the entities to which an applicant authorizes the release of FCVS materials. Such entities may include state medical boards, state osteopathic boards, and other entities that may be subject to state and federal public information or open records laws, which might require the release of certain FCVS packet information to the public upon request.

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

Ye Peng

Applicant's Printed Last Name

11/29/11

Date of Signature (must correspond to date of notarization)

State of Ohio, County of Cuyahoga,
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 29TH day of NOVEMBER, 2011.

Notary Public Signature: Patricia M Podbielski

My Notary Commission Expires: 1/20/2014

222308 222308 215294000


The Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Kevin Caldwell
Federation Credentials Verification Service

December 12, 2011
Date

222308


The Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Kevin Caldwell
Federation Credentials Verification Service

**December 12, 2011**

Date

222308

# 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 Rd**
**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:** Case Western Reserve University School of Medicine

**Address Line 1:**
Office of the Registrar, T-408

**Address Line 2:**
10900 Euclid Avenue

**City:** Cleveland **State/Province:** OH **Zip Code (Postal Code):** 44106-4968

**Country:** US

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

**Premedical Education:**
Years of education required for admission to your medical school: 4
Credential/degree presented by the applicant for admission to your medical school: Bachelor's Degree

**Enrollment and Participation:** Our records indicate that YE PEGGY PENG
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 180 weeks of medical education on the following dates: From: 8 5 2004 (Month Day Year) To: 5 18 2008 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 5 18 2008 (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.

SEAL VERIFIED

**Name:** Siu Yan Scott
**Signature:**
**Title:** Siu Yan Scott, Registrar
Ph: 216-368-6621 // Fax: 216-368-4621
**Date of Signature:** 12 14 11
Email: sns12@case.edu
**Fax:** ( ) **Email:**

222308 186 215294000

## Unusual Circumstances

**1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?** ___ YES ✓ 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:

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

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?** ___ YES ✓ 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:

| | | |
|---|---|---|
| Academic Probation | From (Mo/Yr)___/____ | To (Mo/Yr)___/____ |
| Probation for unprofessional conduct/behavioral | From (Mo/Yr)___/____ | To (Mo/Yr)___/____ |
| Probation for other reason | From (Mo/Yr)___/____ | To (Mo/Yr)___/____ |

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?** ___ YES ✓ NO

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

**4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university?** ___ YES ✓ NO

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

___ YES ✓ NO

**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?**

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



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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS



## Medical School

**Medical Professional Name: Peng Ye**

**Case Western Reserve University School 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 Peng Ye

**PROVIDED BY APPLICANT**

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

CASE WESTERN RESERVE UNIVERSITY EST. 1826

Office of Student Affairs & Multicultural Programs
10900 Euclid Avenue
Cleveland, Ohio 44106-4966
Visitors and Deliveries
2109 Adelbert Road
Phone 216.368.2212
Fax 216.368.8597

November 1, 2007

MEDICAL STUDENT PERFORMANCE EVALUATION
FOR

PEGGY PENG YE

Peggy Peng Ye is a fourth-year student at Case Western Reserve University School of Medicine in Cleveland, Ohio.

**ACADEMIC HISTORY**

| | |
|---|---|
| Date of Expected Graduation from Medical School: | May 2008 |
| Date of Initial Matriculation in Medical School: | August 2004 |
| Extensions, Leave of Absence: | Not applicable |
| *For Transfer Students:* | Not applicable |
| Date of Initial Matriculation in Prior Medical School: | |
| Date of Transfer from Prior Medical School: | |
| *For Dual Degree/Combined Degree Students:* | Not applicable |
| Date of Initial Matriculation in Other Degree Program: | |
| Date of Expected Graduation from Other Degree Program: | |
| Type of Other Degree Program: | |
| Repeated Courses, Adverse Actions: | Not applicable |

**ACADEMIC PROGRESS**

UNDERGRADUATE SCHOOL
Ms. Ye entered Case Western Reserve University in 2000 as a recipient of the Trustee's Scholarship, Robert C. Byrd Honors Scholarship, and Ohio Academic Scholarship. Accepted into the Pre-Professional Scholar's program in Medicine, she satisfied all scholastic and pre-medical requirements and graduated *summa cum laude* with the B.S. degree in Biology in 2004, with minors in Chemistry and Asian Studies. For her outstanding performance as an undergraduate, Ms. Ye was named to the Dean's High Honors list six times, was inducted into the Golden Key National Honor Society and Phi Beta Kappa Honors Society, was awarded a Case Alumni Association Junior/Senior Scholarship, and received the Russell M. Lawall Prize for excellence in Biology. She gained valuable experience in the research process while involved in several projects as a student, one of which resulted in a publication reporting a Bcr/Abl kinase assay in *Cytometry A* in 2003.

PRECLINICAL/BASIC SCIENCE CURRICULUM
Performance in the first two years of our curriculum is evaluated on a pass/fail basis and no calculation of class rank is possible. Ms. Ye's performance in the Core Academic Program and Patient-Based Program

met expectations in all respects. It was stated that in a group setting she was an outstanding participant and she greatly exceeded expectations in all areas. She always contributed very well to the group and provided quiet but very effective leadership for the group. She was very insightful and according to a number of evaluators, she was very receptive to constructive feedback. In the family clinic setting, it was stated that she did an outstanding job and over the two-year period. She developed a wonderful therapeutic relationship with her patients and was very involved in all aspects of patient care and occasionally spoke to the patient outside of the clinic to stay on top of any medical issues. This resulted in her receiving and outstanding evaluation in family clinic. Overall her evaluation was commendable.

CLINICAL CURRICULUM

BASIC CORE I (MetroHealth Medical Center)

Family Medicine: **Commendable.** "She had good rapport with patients, good fund of knowledge.' 'Good rapport with patients and families, good response to feedback.' 'She had excellent written notes, pertinent information present, good listening skills, excellent at inserting patient education into visits."

Internal Medicine: **Commendable.** "Peggy did a thorough job summarizing a patient's history of present illness, and was able to present the information in a concise manner.' 'Ms Ye has been professional at all times, but also comes across as being confident and at ease with patients. This has been important for patient care, in that she is able to establish trust with the patients.' 'Peggy's notes and initial histories and physicals were well-organized. Her presentations were very good. She is eager to learn."

Surgery: **Commendable.** "Peggy was a very good student with the qualities needed to excel in medicine. Her presentations were well-organized and showed improvement over the rotation. She was well prepared for conferences and OR cases. In the clinic, she was noted to have interpreted the available data well, understood available options and the elements of informed consent pertaining to these options. She was able to do a good job with a focused, problem-based H&P and was friendly and interactive with patients. She did a good job in eliciting and assimilating information and developing plans appropriate for clinical situation. Peggy was dependable in getting her work done and helpful with the inpatient team."

BASIC CORE II (University Hospitals Case Medical Center/Veterans Administration)

Neuroscience: **Honors**. "Future Dr. Ye exhibited excellent eagerness, attentiveness, seriousness, and receptiveness to learning during her first two weeks on the Neurology rotation. She made a strong effort to involve herself in the work of the team, including the less glamorous aspects of patient care (extracting key descriptions of non-epileptic seizures for entry into the patient's chart, and assisting in clearing an ear canal so the TM could be inspected in a patient with facial nerve dysfunction). She involved herself closely in several of the consultations - a man with status epilepticus, and man with benign positional vertigo, a man with an unusual Bell's palsy. Given the severe limitations on the time students have to spend on the wards during the neurology rotation, I think she did an outstanding job of maximizing her patient contact! She was also highly attentive during work and teaching rounds, taking notes, asking good questions, and consistently making the most of the experience. If she can produce a formal write-up with thoughtful discussions that evidence some research into the differential diagnosis (as opposed to the more telegraphic write-ups that we allow students to do in the patients' actual charts), she has the potential to turn in an outstanding overall performance for the rotation. Ms. Ye was a valuable team player -- by collecting and summarizing information. Thus, she organized the test results with a discussion of a patient with undiagnosed white matter disease, who presented with progressive bradycinesia and cognitive slowing; Reliable, conscientious, appropriate, and appreciated by her colleagues; Good at presenting differential diagnoses in a well thought-out summary; She was able to thoughtfully application of basic studies to clinical problems. Ms. Ye was a conscientious, enthusiastic medical student, who was good with patients (some of them difficult to deal with) and made very good synopses of diagnostic problems in her write-ups. Peggy did a great job on the VA service. She had competent oral and written case presentations; Good knowledge of neuroanatomy; excellent history taking."

Obstetrics/Gynecology: **Commendable.** "She is a hard worker, always interested in learning, could be more aggressive in seeking feedback."

Pediatrics: **Commendable.** "Peggy gave an excellent performance during her core pediatric rotation at Rainbow Babies and Children's Hospital. Peggy was able to elicit accurate histories in both the inpatient and outpatient settings. As the month evolved, Peggy also further developed her ability to use this historical information to generate differential diagnoses and treatment plans. She demonstrated a good pediatric knowledge base. Her preceptor in the newborn nursery specifically praised her presentation on neonatal feeding methods. Her clinical presentations contained all appropriate details and showed improved organization over the course of the month. By the end of the rotation, she was able to produce a well-written, problem-focused note. She worked well with the children and their families and specifically showed good instincts toward making the children feel comfortable. She was professional and appropriate in her interactions with other members of the health care team. Overall, this has been an excellent performance in pediatrics."

Psychiatry: **Commendable.** "Student Doctor Peggy Ye did an excellent job on her Psychiatry clerkship. Attending comments included 'Good rapport with patients and thorough case presentations', 'Presentation was well organized and well presented. You obviously did considerable work with the patient.' Resident comments included 'Peggy was very professional and caring in her interaction with the patients. She had good attention to detail, and was able to formulate a thorough assessment of a complicated patient. she showed her interest in learning and was a valuable addition to the treatment team while on service', 'Peggy was consistently reliable and punctual, demonstrating a cooperative and pleasant attitude towards both patients and staff', very professional and dedicated, was willing to stay late to assess a complicated patient in the ED', 'Peggy was effective at presenting cogent case summaries and relating them to the management of current patients', 'Peggy excelled in her enthusiasm for acquiring knowledge gleaned from her readings and applying them to patient care', 'Regarding patient care responsibilities Peggy's strength lay in her ability to connect instantly with her patients and place them at ease. This I found to be a skill of fundamental importance, as the population of patients we often dealt with suffered from various psychological and social disadvantages that impaired their ability to interact effectively with others, 'worked well with the entire team', 'An all around excellent student, a pleasure to work with!" Peggy earned an overall Clinical Activity Assessment grade of 'Commendable' for her Psychiatry clerkship."

ADVANCED CORE ROTATIONS: These consist of 4 separate, required 4-week rotations that are completed in any order. The 4 domains for these experiences are: Chronic Illness, Aging in Men and Women, Peri-Operative Care and Pain Management, and Undifferentiated Care.

Advanced Core—Aging in Men and Women (MetroHealth Medical Center): **Satisfactory.**

Radiology (University Hospitals Case Medical Center): **Honors.**

Reproductive Health Externship (Preterm Clinic): **Honors.**

Obstetrics Acting Internship (University Hospitals Case Medical Center): **Honors.** "Peggy was an enthusiastic and active member of the OB team. She was noted to function at an intern level by several different evaluators. She was technically adept in the operating room and actively sought out experiences. Her skills steadily improved throughout her rotation. Peggy wasn't content with just information, but strode to understand concepts as well. Peggy can improve by speaking up more and more actively formulating plans of care."

Acting Internship: Medicine (MetroHealth Medical Center): **Honors.** "Very strong performance, no obvious areas for improvement. Peggy has very good organizational skills and good clinical judgment."

**UNIQUE CHARACTERISTICS**

Peggy was involved in a number of projects during her four year tenure here at the School of Medicine. The summer of 2005-2006, she was a Crile research fellow and her work was performed at the Cleveland Clinic Foundation in the Department of Bioethics. Her project was to analyze language used to disclose

prognosis in childhood leukemia. This resulted in a poster presentation for Case's Lepow Research Day entitled "Disclosure of Prognosis in Childhood Leukemia".

In addition, Peggy has been involved in a number of extracurricular activities: one of which she was a member on Community of Student Representatives (CSR), she was a secretary for one year, and for two years she was on Faculty Council. She also was a member of the Asian Pacific American Medical Student Association and contributed to their newsletter. She also volunteered for the Healthy Boys and Girls organization.

**SUMMARY**
In summary Ms. Ye is a bright hard-working, highly dependable and highly motivated, caring senior medical student who has demonstrated consistent growth and excellent initiative in her approach to her medical education. Her performance in the core clinical clerkships has been consistent and solid with her overall evaluations falling in the commendable range. Ms. Ye possesses a solid knowledge base and expanding clinical acumen including mature clinical judgment. Her interpersonal skills are strong and she works extremely well with her patients and members of the healthcare team.

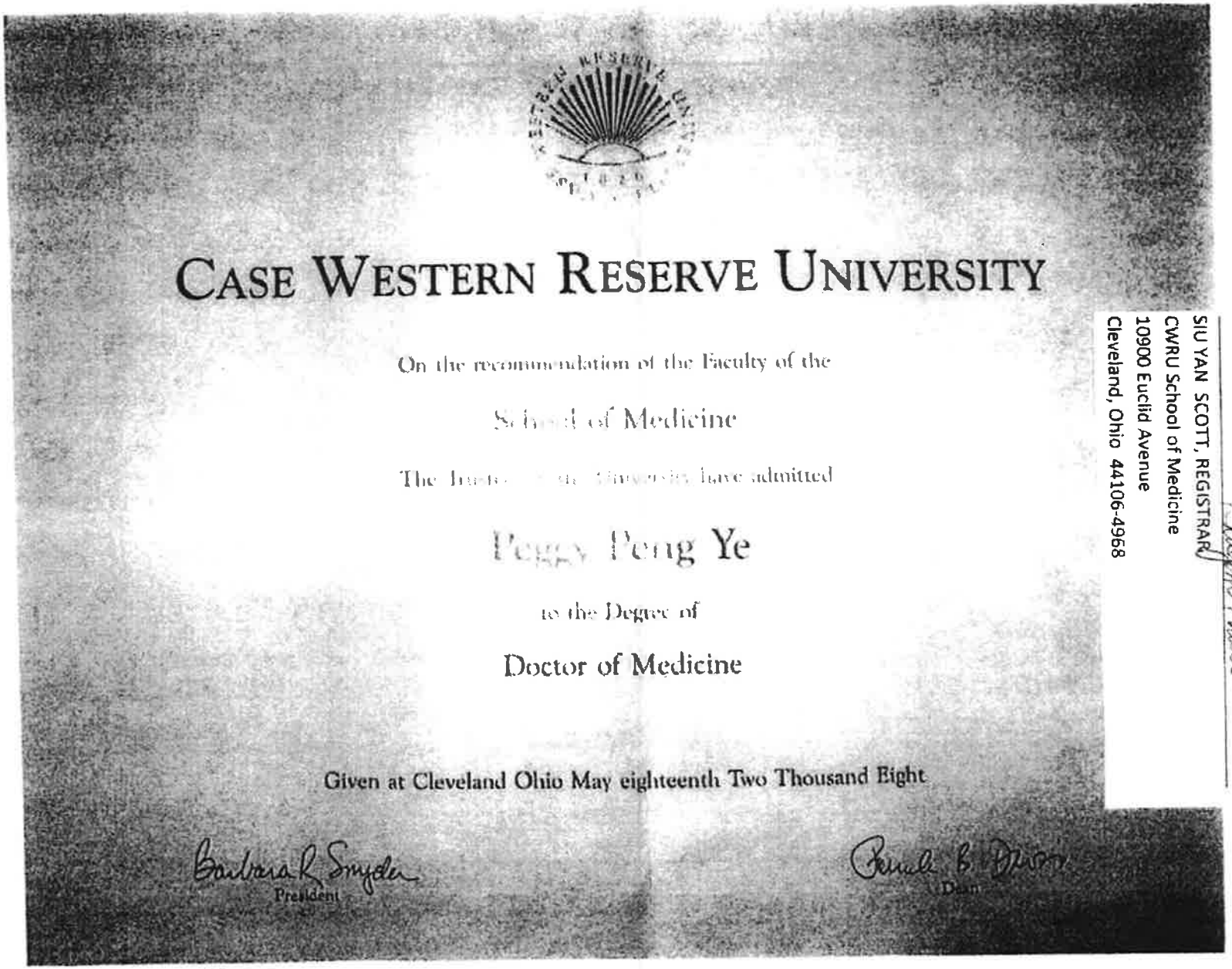
It is a great pleasure to present Ms. Ye to you as a very good candidate for residency training.

Sincerely,

Robert Haynie, M.D., Ph.D.
Associate Dean for Student Affairs

RH:ch

For your information, the School of Medicine will elect students from the Class of 2008 to the Alpha Omega Alpha Honor Medical Society in December of 2007.



# CASE WESTERN RESERVE UNIVERSITY

On the recommendation of the Faculty of the

School of Medicine

The Trustees of the University have admitted

Peggy Peng Ye

to the Degree of

Doctor of Medicine

Given at Cleveland Ohio May eighteenth Two Thousand Eight

Barbara R. Snyder
President

Pamela B. Davis
Dean

SEAL
VERIFIED

SIU YAN SCOTT, REGISTRAR
CWRU School of Medicine
10900 Euclid Avenue
Cleveland, Ohio 44106-4968

This is a true certified copy of the original diploma issued
to _____
on _____

Siu Yan Scott

# 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) 868-4292

## Verification of Graduate Medical Education

Institution: Case Western Reserve Univ - University Hospitals of Cleveland

Address: Department of Obstetrics/Gynecology
Cleveland, OH 44106

Attention: **Program Director**

Affiliated University: University Hospitals Case Medical Center

**Verification For:**

Name: **Ye, Peng**

DOB:

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

**Program Participation:**

**Important:**

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

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

Report Internships, Residencies and Fellowships separately.

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

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

**Specialty/Subspecialty:** OB/GYN
**From:** 06/24/08 **To:** 06/24/2009
**Successfully Completed?:** ☒Yes ☐No ☐In Progress
**Accredited by:** ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

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

**Specialty/Subspecialty:** OB/GYN
**From:** 06/24/2009 **To:** 06/24/2011
**Successfully Completed?:** ☒Yes ☐No ☐In Progress
**Accredited by:** ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

**Training Level:** 4 (e.g., 1, 2, 3, etc.)
☐Internship ☐Residency ☒Chief Residency ☐Fellowship ☐Research

**Specialty/Subspecialty:** OB/GYN
**From:** 06/24/2011 **To:** 06/30/2012
**Successfully Completed?:** ☐Yes ☐No ☒In Progress
**Accredited by:** ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

**Unusual Circumstances:**

Check the correct response. Omitted responses require written explanation.

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

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

**Please explain any "Yes" response from above:**

_____

_____

**Certification:**

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

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:** Nancy J. Cossler, M.D.

**Signature:** Nancy J. Cossler, M.D.

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

**Date of Signature:** 12/13/2011

Tel: 216-844-8551 Fax: 216-201-4239 E-Mail: nancy.cossler@uhhospitals.org

Rev. 09/07/05

FCVS ID:222308 FID: 215294000 FFF CODE 101704

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS



## Graduate Medical Education

**Medical Professional Name: Peng Ye**
**Case Western Reserve Univ - University Hospitals o**
**Obstetrics and Gynecology**

## 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 Peng Ye

**PROVIDED BY APPLICANT**

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

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

**Medical Professional Information Profile**

Federation of STATE MEDICAL BOARDS

# 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) 868-4041**

**Date :** 02/08/2012

**Recipient:**

Federation Credentials Verification Service
ATTN: FCVS

**Packet ID:** 222308

**Examinee:** Ye, Peng
**Alt Name(s):**

**Examinee ID#:** 5-180-252-8
**Date of Birth:**

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

## USMLE STEP 1

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | **Test Date** | **Pass/Fail** | **Total** | **MP** | **Total** | **MP** | **Comments** |
| | 06/30/2006 | Pass | | | | | |

## USMLE STEP 2

**Clinical Knowledge (CK)**

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | **Test Date** | **Pass/Fail** | **Total** | **MP** | **Total** | **MP** | **Comments** |
| | 10/12/2007 | Pass | | | | | |

**Clinical Skills (CS)***

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | **Test Date** | **Pass/Fail** | **Total** | **MP** | **Total** | **MP** | **Comments** |
| | 10/18/2007 | Pass | | | | | |

## USMLE STEP 3

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | **Test Date** | **Pass/Fail** | **Total** | **MP** | **Total** | **MP** | **Comments** |
| OHIO | 04/06/2010 | Pass | | --- | | -- | |

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