State Medical Board of Ohio

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

69209

APPLICATION FOR TRAINING CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

NOTE: Application fee is $75.00. Fees submitted are neither refundable nor transferable.

PERSONAL INFORMATION

Check only one: ☒ MD ☐ DO

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

U.S. Social Security Number: Redacted

Full Name (Use no initials):	Last (Surname)	First	Middle	Suffix (Jr., II)
	Boraas Alsleben	Christy	Marie	

Preferred Name

~~Maiden~~ Name Or Other Names Used (If none, enter "NONE"):	Last (Surname)	First	Middle	Suffix (Jr., II)
	Boraas	Christy	Marie	

Physicians Address (Be sure to notify the Board of any change in address):	Number & Street			
	5337 48th Ave S			
	City	State	Zip Code	Country
	Minneapolis	MN	55417	USA

TRAINING PROGRAM INFORMATION

Training Program Address (Hospital in Ohio where you will be starting your training):	Hospital & Department		
	The Ohio State University Medical Center, Dept. of OB/GYN		
	Number & Street		
	1654 Upham Drive, Means Hall #539		
	City	State	Zip Code
	Columbus	OH	43210

Dates of Training: Beginning Date: Mo/Day/Yr 7/1/08 Ending Date: Mo/Day/Yr 6/30/012

J-1 and H-1B VISA

To be completed by International medical school graduates only:

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

If YES check which one? ☐ J-1 ☐ H-1B

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MEDICAL OR OSTEOPATHIC EDUCATION

Medical or Osteopathic School of Graduation:

School Name: University of MN Medical School
City: Minneapolis | State: MN | Country: USA

Dates Attended: From: Mo/Yr 08/04 To: Mo/Yr 05/08

Degree Received: M.D. Date Received: Mo/Day/Yr 5/2/08

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

School Name: NONE
City | State | Country

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

Reason degree not received at this school:

FIFTH PATHWAY PROGRAM

Fifth Pathway Program **(if none, enter "NONE")**:

Hospital or Institution: NA
Name of Medical School
City | State | Country

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

ECFMG CERTIFICATE

To be completed by International medical school graduates only:

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

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

Applicant Name:_____ Date:_____

PHYSICAL DESCRIPTION

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

Birth Date: Mo/Day/Yr 11/27/78

Birth Place: City Willmar | State MN | Country USA

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

Date Photo Taken: 7/08 mo/yr

PHYSICAL DESCRIPTION

Height 5'7"
Weight 140
Hair Color Brown
Eye Color Blue
Identifying Marks _____

LICENSES IN THE UNITED STATES & CANADA

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

STATE/PROVINCE	ISSUE DATE	LICENSE #	TYPE OF LICENSE	LICENSE CURRENT
	MO/YR		*✓ONLY ONE*	*✓ONLY ONE*
NA			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date: _____
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date: _____
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date: _____

Applicant Name:_____ Date:_____

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES

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

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

From Month/Year ___/___	Hospital, University, Other or non-working activity	Position & Department	%Clinical
	Complete Street Address		
To Month/Year ___/___	Number & Street		%Admin.
	City · State/Country · Zip Code		

From Month/Year ___/___	Hospital, University, Other or non-working activity	Position & Department	%Clinical
	Complete Street Address		
To Month/Year ___/___	Number & Street		%Admin.
	City · State/Country · Zip Code		

From Month/Year ___/___	Hospital, University, Other or non-working activity	Position & Department	%Clinical
	Complete Street Address		
To Month/Year ___/___	Number & Street		%Admin.
	City · State/Country · Zip Code		

From Month/Year ___/___	Hospital, University, Other or non-working activity	Position & Department	%Clinical
	Complete Street Address		
To Month/Year ___/___	Number & Street		%Admin.
	City · State/Country · Zip Code		

From Month/Year ___/___	Hospital, University, Other or non-working activity	Position & Department	%Clinical
	Complete Street Address		
To Month/Year ___/___	Number & Street		%Admin.
	City · State/Country · Zip Code		

Applicant Name:______________________ Date:______________

From Month/Year / To Month/Year /	Hospital, University, Other or non-working activity Complete Street Address Number & Street City State/Country Zip Code	Position & Department	%Clinical %Admin.
From Month/Year / To Month/Year /	Hospital, University, Other or non-working activity Complete Street Address Number & Street City State/Country Zip Code	Position & Department	%Clinical %Admin.
From Month/Year / To Month/Year /	Hospital, University, Other or non-working activity Complete Street Address Number & Street City State/Country Zip Code	Position & Department	%Clinical %Admin.
From Month/Year / To Month/Year /	Hospital, University, Other or non-working activity Complete Street Address Number & Street City State/Country Zip Code	Position & Department	%Clinical %Admin.
From Month/Year / To Month/Year /	Hospital, University, Other or non-working activity Complete Street Address Number & Street City State/Country Zip Code	Position & Department	%Clinical %Admin.
From Month/Year / To Month/Year /	Hospital, University, Other or non-working activity Complete Street Address Number & Street City State/Country Zip Code	Position & Department	%Clinical %Admin.

Applicant Name:______________________ Date:______________

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
ADDITIONAL INFORMATION

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a ***separate sheet of paper (DO NOT write explanations on these pages)***. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

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

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

Applicant Name: [signature] CHRISTY BORAAS algleben Date: 4/4/08

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

Applicant Name: CHRISTY BORRAS ALSLEBEN Date: 4/4/08

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

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

* *

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

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

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

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

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

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

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

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Applicant Name: CHRISTY BORAAS ALSLEBEN Date: 4/4/08

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

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

* *

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

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

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

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

Applicant Name: CHRISTY BORAAS ALSLEBEN Date: 4/4/08

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
MALPRACTICE CLAIM INFORMATION

This form must be competed if you have been named as a defendant in a malpractice lawsuit, verdict or settlement. *Make additional copies of this form as necessary for multiple claims.*

Name of Physician (print clearly): NA

MALPRACTICE COMPLAINT:

Name of Patient: _____

Patients Gender: ❑ Male ❑ Female Age of Patient: _____

Date of Incident: _____ Date Suit Filed: _____

Location of incident: _____
Hospital, institution or other

_____
Address

_____
City State Zip Code County

Name and Address of Involved Insurance Carrier: _____

_____

FILED AGAINST: ❑ Individual Physician ❑ Group ❑ Hospital

Your Position in Case: ❑ Resident ❑ Primary Physician ❑ Other: _____

List names of other defendant-physicians and/or hospitals: _____

_____

DISPOSITION: ❑ Pending ❑ Jury Verdict ❑ Settled ❑ Dismissed ❑ Dropped

If settled, provide the following information: ❑ In Court ❑ Out of Court

Name of Court: _____

Date of Settlement: _____ Docket #: _____

Total amount of settlement: $_____ Amount attributable to you: $_____

You must provide a detailed written explanation of the background and medical issues involved in the case. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach separate sheet. Submit copies of the complaint, answer, release, settlement documents and all other relevant legal documents. Be sure to have your malpractice insurance carrier(s) provide a complete claims history report.

_____

_____

_____

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Physician's Signature Date

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

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

ss STATE OF: MN

COUNTY OF: Hennepin

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

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

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

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

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

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

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

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

Signature of Applicant

Subscribed and sworn to before me this 7th day of April 20 08.

ELIZABETH A MOEN
Notary Public
Minnesota
(NOTARY SEAL)
My Commission Expires Jan. 31, 2012

Signature of Notary Public

January 31, 2012
Date Commission Expires

THIS FORM CANNOT BE FAXED

State Medical Board of Ohio

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

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
CERTIFICATION OF TRAINING PROGRAM

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

THIS SECTION TO BE COMPLETED BY APPLICANT

Name of Applicant: Boraas (Last) Christy (First) Alsleben (Middle) (Suffix (Jr., II))

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: The Ohio State University / Mt. Carmel Health

Training Program Address: 1654 Upham Drive, Means Hall #539 (Street Address)

Columbus (City) OH (State) 43210 (Zip Code)

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

Specialty (*see reverse side*): Obstetrics & Gynecology

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

Dates of Training (***not to exceed one year***): Beginning Date: MO/DAY/YR 7/1/08 Ending Date: MO/DAY/YR 6/30/09

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

HOSPITAL SEAL

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

Signature of Medical Director or Program Director

Philip Samuels, MD

Name (please print)

4/7/08

Date

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 2 - VERIFICATION OF LICENSE

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian Province in which I hold or have held a license, whether now current or not. Please complete the form and return it *directly* to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name: NA
last first middle suffix (Jr., II)

License Number:_____ Date of Birth:_____
month/day/year

I hereby authorize the licensing agency of the State of _____
to furnish the information below to the State Medical Board of Ohio.

_____ _____
Signature of Applicant Date

THIS SECTION TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province:_____

Name of Licensee:_____
last first middle suffix (Jr., II)

License Number: _____ Issue Date: _____ Expire(d):_____
month/day/year month/day/year

License Type: ❑ full, unrestricted ❑ temporary ❑ training certificate
❑ educational ❑ limited permit ❑ other:_____
(please specify)

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? ❑ Yes ❑ No ❑ Cannot answer under current state law ***If yes, please attach complete details.***

Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? ❑ Yes ❑ No ❑ Cannot answer under current state law ***If yes, please attach complete details.***

Has the applicant ever been warned, censured or in any other manner disciplines or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?
❑ Yes ❑ No ❑ Cannot answer under current state law ***If yes, please attach complete details.***

AFFIX BOARD SEAL

(NOT VALID WITHOUT SEAL)

_____
Signature

_____
Title

_____
Date

OHIO STATE MEDICAL BOARD

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TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 3 - CERTIFICATION OF ECFMG
GRADUATES OF SCHOOLS LOCATED OUTSIDE THE UNITED STATES OR CANADA ONLY

Instructions to Hospital Training Program: If you receive verification of ECFMG status directly from ECFMG, please complete the form below and return directly to the State Medical Board of Ohio at the above address. ***You must also attach a copy of the applicant's ECFMG status report.***

THIS SECTION TO BE COMPLETED BY APPLICANT

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

ECFMG Certificate Number:_____ Expiration Date:_____

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program:_____

Training Program Address:_____
Street Address

_____
Department

_____
City State Zip Code

I hereby CERTIFY that I received verification of the ECFMG status report for the above-named applicant, directly from ECFMG. I have attached a copy of the ECFMG status report.

HOSPITAL SEAL

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

_____
Signature of Medical Director or Program Director

_____
Name (please print)

_____
Date

OHIO STATE MEDICAL BOARD

THIS FORM CANNOT BE FAXED

APR 18 2008

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State Medical Board of Ohio

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

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
VERIFICATION OF FIFTH PATHWAY PROGRAM

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

THIS SECTION TO BE COMPLETED BY APPLICANT

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

Fifth Pathway Program: _____

Medical/Osteopathic School: _____

I hereby authorize my fifth pathway program to furnish the information below to the State Medical Board of Ohio.

_____ _____
Signature of Applicant Date

THIS SECTION TO BE COMPLETED BY MEDICAL SCHOOL

This certifies that _____ has completed a Fifth Pathway program at
(name of applicant)

_____ affiliated
(name of hospital or institution)

with _____
(name of medical school)

located in _____
City State Country

which is approved by the Liaison Committee on Medical Education. The above-named applicant's duties were discharged from ____/____/____ to ____/____/____.
beginning (mo/day/yr) ending (mo/day/yr)

MEDICAL SCHOOL SEAL

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

_____
Signature of Dean or Director
(Original signatures only, name stamps will not be accepted)

_____
Name (please print or type)

_____
Position

_____
Telephone Number (include area code)

OHIO STATE MEDICAL BOARD

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

THIS FORM IS NOT TO BE COMPLETED PRIOR TO GRADUATION

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

THIS SECTION TO BE COMPLETED BY APPLICANT

Name: Boraas Alcleben (Last) Christy (First) Marie (Middle) (Suffix (Jr., II))

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

Location: Minneapolis (City) MN (State)

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

Signature of Applicant _____ Date 4/4/08

THIS SECTION TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that Borass Alsleben, Christy Marie (Last, First, Middle, Suffix (Jr., II))

attended medical/osteopathic school from 08/09/04 (mo/day/yr) to 05/03/08 (mo/day/yr)

This individual *(check one)*:

- ☑ was awarded the degree of DOCTOR OF MEDICINE on 05/03/08 (mo/day/yr)
- ☐ was not awarded a degree (please attach an explanation)

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

AFFIX INSTITUTIONAL SEAL

(If your institution does not have an Official seal, please Indicate and have form notarized)

Signature _____

THEODORE R. THOMPSON, M.D.
Name (please print)

DIR. OF CLINICAL EDUCATION
Title

06/09/08
Date

THIS FORM CANNOT BE FAXED

State Medical Board of Ohio

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

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
CERTIFICATION OF TRAINING PROGRAM

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

THIS SECTION TO BE COMPLETED BY APPLICANT

Name of Applicant: Boraas (Last) Christy (First) (Middle) (Suffix (Jr., II))

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: Ohio State University / Mt. Carmel Health

Training Program Address: 1654 Upham Drive, Means Hall # 539 (Street Address)

Columbus (City) OH (State) 43210 (Zip Code)

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

Specialty (*see reverse side*): Obstetrics & Gynecology

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

Dates of Training (***not to exceed one year***): Beginning Date: MO/DAY/YR 6/30/08 Ending Date: MO/DAY/YR 6/30/09

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

HOSPITAL SEAL

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

Signature of Medical Director or Program Director

Philip Samuels, MD

Name (please print)

6/12/08

Date

OHIO STATE MEDICAL BOARD

JUN 16 2008

RECEIV

THIS FORM CANNOT BE FAXED

7/28/2008

Christy Marie Boraas Alsleben, MD
Ohio State University Hospitals
c/o Corporate Credentialing, Attn: Anne Smith
700 Ackerman Road Suite #570
Columbus OH 43202

NUMBER: **57-014608**
HOSPITAL: **Ohio State University Hospitals**
Obstetrics & Gynecology

DATES: **06/30/2008 - 06/29/2009**

Dear Doctor:

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

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

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

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

Sincerely,

Penny E. Grubb
Chief, Licensure

Date Posted: 5/25/2009 8:20:11 PM

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

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

Address Information

MAIN

2425 Marblevista Blvd
Columbus, OH 43204
Franklin County
United States of America
christy.boraas@osumc.edu

License Information

License Number 57.014608
License Name Christy Boraas Alsleben

Fees

Relicensure Fee $35.00
========
Total Fees **$35.00**

TC-Change programs

1. Are you currently training at the Training program previously listed?
. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
. . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
. . . . . NO
3. Have you been disciplined or notified of an investigation of you by your training program for other than academic performance?
. . . . . NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?
. . . . . NO
5. Have you had any clinical privileges or other authority to practice suspended or

revoked by any institution or program or have you been placed on probation for any reason other than academic performance?

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

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

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

Date Posted: 4/12/2010 8:50:39 AM

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

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

License Information

License Number	57.014608
License Name	Christy Boraas Alsleben

Fees

Relicensure Fee	$35.00
	========
Total Fees	**$35.00**

TC-Change programs

1. Are you currently training at the Training program previously listed?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

3. Have you been disciplined or notified of an investigation of you by your training program for other than academic performance?

. . . . . NO

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

. . . . . NO

5. Have you had any clinical privileges or other authority to practice suspended or revoked by any institution or program or have you been placed on probation for any reason other than academic performance?

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

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

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

Date Posted: 3/24/2011 9:29:48 AM

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

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

License Information

License Number 57.014608

License Name Christy Boraas Alsleben

Fees

Relicensure Fee $35.00

========

Total Fees **$35.00**

TC-Change programs

1. Are you currently training at the Training program previously listed?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

3. Have you been disciplined or notified of an investigation of you by your training program for other than academic performance?

. . . . . NO

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

. . . . . NO

5. Have you had any clinical privileges or other authority to practice suspended or revoked by any institution or program or have you been placed on probation for any reason other than academic performance?

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

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

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

Contact Audit Trail for BORAAS ALSLEBEN CHRISTY

Date	User	Table	Field	New	Old
11/10/2010 8:58:59 AM	Moore, A	CONTACTADDRESS	ACTIVE	Deleted	Active
11/10/2010 8:58:43 AM	Moore, A	CONTACTADDRESS	ADDRESS1	2425 Marblevista Blvd.	2425 Marblevista Blvd
11/10/2010 8:58:43 AM	Moore, A	CONTACTADDRESS	PHONE	6142934532	
11/10/2010 8:58:43 AM	Moore, A	CONTACTADDRESS	COUNTRYIDNT		United States of America
11/10/2010 8:58:34 AM	Moore, A	CONTACT	TITLE	Dr.	
5/26/2009 12:33:27 PM	Vest, P	CONTACTADDRESS	COUNTYID	Franklin	
5/26/2009 12:33:27 PM	Vest, P	CONTACTADDRESS	COUNTRYIDNT	United States of America	
5/26/2009 12:33:26 PM	Vest, P	CONTACTADDRESS	ZIPCODE	43204	55417
5/26/2009 12:33:26 PM	Vest, P	CONTACTADDRESS	STATECODE	OH	MN
5/26/2009 12:33:26 PM	Vest, P	CONTACTADDRESS	CITY	Columbus	Minneapolis
5/26/2009 12:33:25 PM	Vest, P	CONTACTADDRESS	ADDRESS1	2425 Marblevista Blvd	5337 48th Avenue S
4/25/2008 4:55:50 PM	Bouldware, G	CONTACT	DATEOFBIRTH	19781127	
4/25/2008 4:55:50 PM	Bouldware, G	CONTACT	BIRTHCITY	Willmar	
4/25/2008 4:55:50 PM	Bouldware, G	CONTACT	BIRTHSTATE	MN	
4/25/2008 4:55:50 PM	Bouldware, G	CONTACT	GENDER	F	
4/25/2008 4:55:37 PM	Bouldware, G	CONTACTADDRESS	ADDRESS1	Ohio State University Hospitals	
4/25/2008 4:55:37 PM	Bouldware, G	CONTACTADDRESS	ADDRESS2	c/o Corporate Credentialing, Attn: Anne Smith	
4/25/2008 4:55:37 PM	Bouldware, G	CONTACTADDRESS	CITY	Columbus	
4/25/2008 4:55:37 PM	Bouldware, G	CONTACTADDRESS	ZIPCODE	43202	
4/25/2008 4:55:37 PM	Bouldware, G	CONTACTADDRESS	ADDRESS3	700 Ackerman Road Suite #570	
4/25/2008 4:55:37 PM	Bouldware, G	CONTACTADDRESS	COUNTYID	Franklin	
4/25/2008 4:55:23 PM	Bouldware, G	CONTACTADDRESS	ADDRESS1	5337 48th Avenue S	
4/25/2008 4:55:23 PM	Bouldware, G	CONTACTADDRESS	CITY	Minneapolis	
4/25/2008 4:55:23 PM	Bouldware, G	CONTACTADDRESS	STATECODE	MN	OH
4/25/2008	Bouldware,	CONTACTADDRESS	ZIPCODE	55417	

4:55:23 PM	G				
4/21/2008 7:57:30 AM	Barnosky,J	CONTACT	OLRPASSWORD	*******	*******

State Medical Board of Ohio

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

VERIFICATION OF LICENSURE

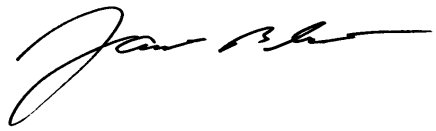
This is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 06/25/2014:

Identification Information

Name and Address:	Dr. Christy Marie Boraas Alsleben 700 Ackerman Road Suite #570 Columbus, OH 43202
Date of Birth:	11/27/1978
Place of Birth:	Willmar, MN
School of Graduation:	University of Minnesota Medical School - Minneapolis
Date of Graduation:	05/03/08

License Information

Type of License:	MD Training Certificate
License Number:	57. 014608
How Issued:	
Original Licensure Date:	07/28/2008
Expiration Date:	06/29/2012
Status:	INACTIVE
Formal Disciplinary Action:	No



Jonathan Blanton
Interim Executive Director

Uniform Application for Physician Licensure

UA Username cboraas **Date Submitted** 11/9/2010
FCVS Status Applicant has an FCVS Packet

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

1. Full Name (use no initials)

Last Name Boraas Alsleben
First Name Christy Marie
Middle Name
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix
		Boraas	

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

Business
[X] **Public Access** **Street** 2425 Marblevista Boulevard
[X] **Mailing**
City Columbus **State/Province** OH **Zip Code** 43204
Telephone 614-293-4532
Fax
Email christy.boraas@osumc.edu
Alternate Phone 614-730-6943

Home
[ ] **Public Access** **Street** 2425 Marblevista Boulevard
[ ] **Mailing**
City Columbus **State/Province** OH **Zip Code** 43204
Telephone 614-293-4532
Fax
Email christy.boraas@osumc.edu
Alternate Phone 614-730-6943

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

3. Identification

11/27/1978	Willmar	Minnesota	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	Redacted			☐ Yes ☐ No
Gender	Social Security Number	NPID	Are you a U.S. Citizen?	

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

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

4. Medical School

1

School Name University of Minnesota Medical School - Minneapolis
Address Box 293
420 Delaware Street, South East

City Minneapolis
State/Province MN
ZIP Code 55455
Country USA
Attendance Dates **From (mm/yyyy)** 08/2004 **To (mm/yyyy)** 05/2008
Graduation Date 5/3/2008
Degree MD

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

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			

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

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

6. Postgraduate Training

1

Hospital Name The Ohio State University

Hospital Address 395 W 12th Avenue

City Columbus

State/Province Ohio

ZIP Code 43210

Country USA

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

Department/Specialty Obstetrics and Gynecology

From: 07 /2008 **To:** 06 /2012 **Successfully Completed?** ☐ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

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

7. Examination History

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

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
			☐ P ☐ F	

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

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

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

9. State Licensure - MD or DO only - attach additional pages if necessary

1 **State/Province**	**Practitioner Type (MD, DO, etc.)**	**Type of License (Full, Temporary, etc**
License Number	**Status**	**Issue Date**

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

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2008 To: Month: Year: In Progress [X]	**Practice/Employment Name** The Ohio State University Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 395 W. 12th Street **City** Columbus **State/Province** Ohio **ZIP Code** 43210 **Country** USA **Position and Department** Resident Physician-Obstetrics an(**% Clinical** 100**% Administrative** **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

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

11. Malpractice Liability Claims Information

Name of patient involved:

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

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

Current status of claim:

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

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

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

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

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