137310

State Medical Board of Ohio

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

Ohio Physician Licensure Application Addendum

1. *Indicate License Type* (•) M.D. ( ) D.O. ( ) M.D. Telemedicine ( ) D.O. Telemedicine

2. *Name: Indicate your full legal name. Please list any maiden names or other names used.*

Last	First	Middle	Suffix
Watson	Jennifer	Marie	

Maiden Name:

All other names used:

3. *Contact Information:* *Please complete all sections*

Indicate which address you wish to use for mailings from the Medical Board. ( ) Practice Address (•) Home Address

Practice Address

Street 1: 11100 Euclid Ave
Phone Number:
Street 2: Office of GME-Lakeside 6223-C
Fax Number: +1 (216) 844-8974
City: Cleveland State: OH Zip Code: 44106
email: jennifer.watson@uhhospitals.org

Home Address

Street 1: 1469 Black Pond Drive
Phone Number: +1 (202) 340-3939
Street 2:
Fax Number:
City: Akron State: OH Zip Code: 44320
email: jenni889@hotmail.com

4. *Identification*

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Date of birth: 4/26/1983
Birth City: Peterborough
State: ON
Country: Canada

SSN: Redacted

Gender: ( ) Male (•) Female

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., 4762., or 4778. O.R.C. or as otherwise required by state or federal law.

5. Preliminary Education. Watson, Jennifer 130375

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High School or equivalent: Thomas A. Stewart Secondary School

City: Peterborough | State: ON | Country: Canada

Date From: 9/1997 | Date To: 6/2002

Undergraduate College 1: Trent University

City: Peterborough | State: ON | Country: Canada

Date From: 9/2002 | Date To: 5/2007 | Degree: Bachelor of Science

Undergraduate College 2: Queen's University

City: Kingston | State: ON | Country: Canada

Date From: 9/2007 | Date To: 5/2008 | Degree: Bachelor of Education

6. TOEFL- IBT. This section is only required to be completed by International Medical School Graduates.

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

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

○ YES ◉ NO Have you completed two years of undergraduate college work in the United States?

◉ YES ○ NO During the five years immediately preceding the date of your application have you:

Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?

○ YES ◉ NO Have you completed a Fifth Pathway program?

◉ YES ○ NO Have you passed the Clinical Skills Assessment exam given by the ECFMG on or before July 1, 1998?

If you answered 'NO' to all of the above, you are required to take the TOEFL-IBT. Please refer to the instructions for information on contacting the Educational Testing Service. The Board cannot waive this requirement.

7. Ohio Training Program.

◉ YES ○ NO Are you or will you be in an accredited training program in Ohio? If yes, please identify the program below.

Program Name: University Hospitals Case Medical Center (Family Medicine)

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8. Military.

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○ YES ◉ NO Are you currently in the United States Military or Reserves or a Military Veteran?

○ YES ◉ NO Are you the spouse of an individual currently serving in the United States Military or Reserves?

9. Medical School: *List all medical schools you have attended, including those from which you did not graduate in chronological order. Attach and additional sheet if necessary.*

1. School Name: Saba University School of Medicine
Address: Saba University School of Medicine
City: The Bottom State: Sab Zip Code:
Country: Netherlands Antilles
Date From: 8/2008
Date To: 5/2012
Graduation Date: 5/25/2012
Degree: Doctor of Medicine (MD)

2. School Name:
Address:
City: State: Zip Code:
Country:
Date From:
Date To:
Graduation Date:
Degree:

10. Postgraduate Training: *List all postgraduate programs you have attended, including those you did not complete. Copy and attach additional pages if necessary.*

1. Hospital Name: University Hospitals Case Medical Center
Address: 11100 Euclid Ave
City: Cleveland State: OH Zip Code: 44106
Country: USA
Department/Specialty: Family Medicine
Date From: 7/1/2012
Date To: 6/30/2013
Successfully Completed? (•) Yes ( ) No
PGY ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) other
PGT ( ) Internship (•) Residency ( ) Fellowship ( ) Research ( ) other

2. Hospital Name: University Hospitals Case Medical Center
Address: 11100 Euclid Ave
City: Cleveland State: OH Zip Code: 44106
Country: USA
Department/Specialty: Family Medicine
Date From: 7/1/2013
Date To: 6/30/2014
Successfully Completed? (•) Yes ( ) No
PGY ( ) 1 (•) 2 ( ) 3 ( ) 4 ( ) 5 ( ) other
PGT ( ) Internship (•) Residency ( ) Fellowship ( ) Research ( ) other

3. Hospital Name: University Hospitals Case Medical Center
Address: 11100 Euclid Ave
City: Cleveland State: OH Zip Code: 44106
Country: USA
Department/Specialty: Family Medicine
Date From: 7/1/2014
Date To: current (anticipate gr
Successfully Completed? (•) Yes ( ) No
PGY ( ) 1 ( ) 2 (•) 3 ( ) 4 ( ) 5 ( ) other
PGT ( ) Internship (•) Residency ( ) Fellowship ( ) Research ( ) other

4. Hospital Name | Date From
Address | Date To
City | State | Zip Code
Country | Successfully Completed? ○ Yes ○ No
Department/Specialty:

PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other

PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

5. Hospital Name | Date From
Address | Date To
City | State | Zip Code
Country | Successfully Completed? ○ Yes ○ No
Department/Specialty:

PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other

PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

11. Examination History: *List each licensure examination you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, copy and attach an additional sheet.*

Examination	Date Taken (mm,yyyy)	Pass / Fail	No. of Attempts
USMLE Step 1	06.2010	◉ Pass ○ Fail	1
USMLE Step 2 CK	07.2011	◉ Pass ○ Fail	1
USMLE Step 2 CS	07.2011	◉ Pass ○ Fail	1
USMLE Step 3	03.2014	◉ Pass ○ Fail	1
COMLEX Level 1		○ Pass ○ Fail	
COMLEX Level 2 CE		○ Pass ○ Fail	
COMLEX Level 2 PE		○ Pass ○ Fail	
COMLEX Level 3		○ Pass ○ Fail	
NBME Part I		○ Pass ○ Fail	
NBME Part II		○ Pass ○ Fail	
NBME Part III		○ Pass ○ Fail	
NBOME Part I		○ Pass ○ Fail	
NBOME Part II		○ Pass ○ Fail	
NBOME Part III		○ Pass ○ Fail	
LMCC Part I	04.2014	◉ Pass ○ Fail	1
LMCC Part II		○ Pass ○ Fail	
FLEX Componet 1		○ Pass ○ Fail	
FLEX Componet 2		○ Pass ○ Fail	
FLEX Pre-1985		○ Pass ○ Fail	

State Board Exam | Date Taken | State taken for | No. of Attempts | Pass / Fail ○ Pass ○ Fail

12. *ECFMG and Fifth Pathway*

Certificate Number: 08740466 Issue Date: 6/4/2012

School Name: Saba University School of Medicine
Address: Saba University School of Medicine
City: The Bottom State: Saba Zip Code:
Country: Netherlands Antilles

Date From: 08/2008
Date To: 5/2012
Graduation Date: 5/25/2012
Degree: Doctor of Medicine (MD)

13. *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 complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any healthcare license or certification. The verifying entity must forward all documentation directly to the 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. (Attach additional pages if necessary).*

	State / Province	License Type	License Number	License Status		Issue Date
1	Ohio	MD Training Cert	57.022027	(•) Active	( ) Inactive	10/26/2012
2				( ) Active	( ) Inactive	
3				( ) Active	( ) Inactive	
4				( ) Active	( ) Inactive	
5				( ) Active	( ) Inactive	
6				( ) Active	( ) Inactive	
7				( ) Active	( ) Inactive	
8				( ) Active	( ) Inactive	
9				( ) Active	( ) Inactive	
10				( ) Active	( ) Inactive	
11				( ) Active	( ) Inactive	
12				( ) Active	( ) Inactive	
13				( ) Active	( ) Inactive	
14				( ) Active	( ) Inactive	
15				( ) Active	( ) Inactive	

14. *Specialty Board Certification:* *Are you ABMS and / or AOA certified?* ( ) Yes (•) No

*If **Yes** complete information below*

Name of Board: Certificate Number: Issue Date:
Name of Board: Certificate Number: Issue Date:
Name of Board: Certificate Number: Issue Date:

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

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 05 Year: 2012

TO: Month: 07 Year: 2012 ○ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Vacation

Activity Address: 166 Clifton Street

City: Peterborough State: ON Zip Code:

Position / Department:

Percent Clinical: Percent Administrative:

○ Employment ○ Staff Privileges ○ Administrative ◉ Other, Please describe below

Vacation between graduation of medical school and start of Family Medicine residency.

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 07 Year: 2012

TO: Month: 1 Year: 2015 ◉ In Progress

Activity Name *(Practice/Employment/Non-Working*)*: Post Graduate Training

Activity Address: University Hospitals Case Medical Center 11100 Euclid Ave

City: Cleveland State: OH Zip Code: 44106

Position / Department: Family Medicine Resident

Percent Clinical: 100% Percent Administrative:

◉ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Residency training. Currently in year 3 of 3-year program

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: Year:

TO: Month: Year: ○ In Progress

Activity Name *(Practice/Employment/Non-Working*)*:

Activity Address:

City: State: Zip Code:

Position / Department:

Percent Clinical: Percent Administrative:

○ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Ohio Addendum to Application
ADDITIONAL INFORMATION QUESTIONS

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

○ Yes ◉ No 1. Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?

○ Yes ◉ No 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?

○ Yes ◉ No 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?

○ Yes ◉ No 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?

○ Yes ◉ No 5. Have you ever transferred from one graduate medical education program to another?

○ Yes ◉ No 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?

○ Yes ◉ No 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?

○ Yes ◉ No 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?

○ Yes ◉ No 9. Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?

○ Yes ◉ No 10. Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?

○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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?
○ Yes	◉ No	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.
○ Yes	◉ No	16. Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
○ Yes	◉ No	17. Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.
○ Yes	◉ No	18. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?
○ Yes	◉ No	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?
○ Yes	◉ No	20. Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?
○ Yes	◉ No	21. Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

○ Yes ◉ No 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?

○ Yes ◉ No 22. 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 of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

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

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

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

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

○ Yes ◉ No 23. Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **You may answer "NO" to this question if** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.

○ Yes ◉ No a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?

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.

○ Yes ◉ No b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

"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?

○ Yes ◉ No 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 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.

○ Yes ◉ No b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

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?

○ Yes ○ No 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.

State Medical Board of Ohio

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Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit and Authorization For Release of Information

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

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

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

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

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

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

Jennifer Watson

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

Watson

Applicant's Printed Last Name

Jennifer Marie

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

1/7/2015

Date of Signature

Notary Public Signature

10/16/18

Date Commission Expires

Subscribed and Sworn to before me on this 7th day of January ,20 15

MEDICAL BOARD
JAN 13 2015

State Medical Board of Ohio

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Recommending physician, print name legibly

I Vanessa Maier, currently hold an active license to practice as a physician in the state of Ohio / license number 35.090004., attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," the photograph affixed hereto is a genuine likeness of the applicant, and provide this recommendation form related to the request for professional licensure by Jennifer Marie Watson

Applicant, print name legibly

1. How do you know this applicant ?
   As her attending physician
2. How would you describe the applicant's medical knowledge ?
   superior
3. How would you describe the applicant's clinical technique ?
   superior
4. How would you characterize the applicant's relationship with the patients ?
   superior
5. How would you the applicant's ability to work with peers and clinical staff ?
   superior
6. Have you personally known the applicant at least six months? ☑ Yes ☐ No
7. Does the applicant possess good moral character? (If no, explain) ☑ Yes ☐ No
8. Do you recommend this applicant for the professional license being sought? (If no, explain) ☑ Yes ☐ No
9. Are you aware of any information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐ Yes ☑ No
10. Have you attached additional correspondence or information to this form? ☐ Yes ☑ No

MEDICAL BOARD
JAN 13 2015

Signature of Recommending Physician (Name stamp not accepted)

11100 Euclid Ave. Cleveland OH 44106
Address (including house number and street, city ,state and zip code

NOTARY

Notary Public Signature

10/13/18
Date Commission Expires

Subscribed and Sworn to before me on this 17th day of December ,20 14

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Recommending physician, print name legibly

I Alexandria Howard MD, currently hold an active license to practice as a physician in the state of Ohio / license number 35.123797, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," the photograph affixed hereto is a genuine likeness of the applicant, and provide this recommendation form related to the request for professional licensure by Jennifer Marie Watson

Applicant, print name legibly

1. How do you know this applicant ?
   Family medicine residency @ university Hospitals case medical center
2. How would you describe the applicant's medical knowledge ?
   above average
3. How would you describe the applicant's clinical technique ?
   excellent
4. How would you characterize the applicant's relationship with the patients ?
   excellent
5. How would you the applicant's ability to work with peers and clinical staff ?
   superior
6. Have you personally known the applicant at least six months? ☒ Yes ☐ No
7. Does the applicant possess good moral character? (If no, explain) ☒ Yes ☐ No
8. Do you recommend this applicant for the professional license being sought? (If no, explain) ☒ Yes ☐ No
9. Are you aware of any information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐ Yes ☒ No

itional correspondence or information to this form? ☐ Yes ☒ No

Signature of Recommending Physician (Name stamp not accepted)

11100 Euclid Ave, Bolwell 1200, Cleveland OH 44106

Address (including house number and street, city, state and zip code

MEDICAL BOARD

JAN 13 2015

NOTARY

Thomas Maurer

Notary Public Signature

10/16/18

Date Commission Expires

Subscribed and Sworn to before me on this 17th day of December, 20 14

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Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Jennifer Marie Watson
Please print applicants first name and last name

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

Position(s) held: Resident

Dates of Employment 7/2012 to present (6/2015)

1. How long have you known the applicant? 3yrs
2. What is/was your supervisory capacity? Residency director
3. At what hospital/ clinic? University Hospitals Case Med Center
4. How would you rate their medical knowledge and techniques? excellent
5. In your opinion is the applicant of good moral and ethical character? yes
6. Does the applicant work well with peers and medical staff? yes
7. Does the applicant relate well to patients? yes
8. How is the applicant's command of the English language (if applicable)? excellent
9. Would you recommend the applicant for licensure? yes

Additional comments (an additional sheet may be added if needed)

Physician Signature: Wanda Cruz-Knight MD MBA

Name of Physician: Wanda Cruz-Knight

Position: Residency Director

Telephone number (include area code) 216-844-5438 Fax number (include area code) 216-844-1030

E-mail wanda.Cruz-Knight@uhhospitals.org

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for

Name: **Jennifer Marie Watson**

Social Security Number: Redacted

Date of Birth: **April 26, 1983**

FID#: **204019566**

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

ABOUT THIS PROFILE

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

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

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

Medical Professional Name: **Jennifer Marie Watson**
Date of Birth: **April 26, 1983**
Social Security Number: Redacted
FID: **204019566**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

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

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

Saba University School of Medicine
1. Medical Education Form and Translation
2. Medical Education Transcript and Translation
3. Medical Education Diploma and Translation

C. Fifth Pathway Program

D. ECFMG Certification

1. ECFMG Certification Status Report

V. Graduate Medical Education

Case Western Reserve University/University Hospitals Case Medical Center Program
1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

X A. FSMB Exam Transcript

End of report for: Jennifer Marie Watson

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name:	**Jennifer Marie Watson**
	Documentation: Certified Birth Certificate OR Copy w/ Cert. of Identification
Gender:	Female
Date of Birth:	April 26, 1983
Place of Birth:	Peterborough,
Social Security Number:	Redacted
FID:	204019566
Physical Description:	Height: 5 ft. 8 in.
	Weight: 160 lbs.
	Eye Color: Blue
	Hair Color: Blond

Contact Information

Mailing Address:	1469 BLACK POND DR AKRON, OH 44320-1513 UNITED STATES
Permanent Address:	1469 BLACK POND DR AKRON, OH 44320-1513 UNITED STATES
Telephone Numbers:	Primary: (202) 340-3939
	Secondary: N/A
	Fax: N/A
	Other: N/A

Pre-medical Education

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

Institution: **Trent University**
Address: Peterborough, K9J7B8
CANADA
Dates of Attendance: 09/--/2002 To 05/--/2007
Degree Conferred/Issued: Bachelor of Science

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

Institution: **Queens's University**
Address: Kingston, K7L3N6
CANADA
Dates of Attendance: 09/--/2007 To 05/--/2008
Degree Conferred/Issued: Associate

ECFMG

ECFMG Number: 08740466
Issue Date: 06/04/2012

Medical Education

Medical School: **Saba University School of Medicine**
Address: PO Box 1000
Church Street
The Bottom,
NETHERLANDS ANTILLES

Dates of Attendance: 09/01/2008 to 05/25/2012
Date Certificate Issued: 05/25/2012
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: **University Hospitals Case Medical Center**
Address: 11100 Euclid Avenue
Bolwell 1200
Cleveland, OH 44106
UNITED STATES

Training Level: 0 - 1
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/2012 To 06/30/2013
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 1 - 2
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/2013 To 06/30/2014
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2 - 3
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/2014 To 06/30/2015
Completed Successfully: In Progress
Accreditation: ACGME

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

Licensure Examinations

FSMB Transcript USMLE Step 1	Date: 06/2010	Passed the Exam
FSMB Transcript USMLE Step 2 CK	Date: 07/2011	Passed the Exam
FSMB Transcript USMLE Step 2 CS	Date: 07/2011	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 03/2014	Passed the Exam

ABMS Verification

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

Board Action

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

End of report for: Jennifer Marie Watson FID: 204019566

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

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

Medical Professional Identification

Medical Professional Name:	**Jennifer Marie Watson**
Date of Birth:	**April 26, 1983**
Social Security Number:	Redacted
FID:	**204019566**

Omissions

Omission 1:

Section of Profile:	**Examination**
Omission:	**The LMCC examination transcript has been omitted from this Profile.**
Action Taken:	**The applicant has insisted that FCVS forward the Medical Professional Information Profile at this time. A letter from the applicant is included in the Examination Section of the Profile.**

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Discrepancies

There are no discrepancies identified.

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Jennifer Marie Watson

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: **Jennifer Marie Watson**
Date of Birth: **April 26, 1983**
Social Security Number: Redacted
FID#: **204019566**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
08/2008	05/2012	Medical Education Record	Saba University School of Medicine,PO Box 1000 The Bottom, NETHERLANDS ANTILLES		
07/2012	07/2015	GME Record	University Hospitals Case Medical Center ,11100 Euclid Avenue Cleveland, OH 44106 UNITED STATES		

End of report for: Jennifer Marie Watson

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Section II

FSMB and Other Reports

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PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:11/4/2014

PRACTITIONER INFORMATION

Name:	Jennifer Marie Watson
DOB:	4/26/1983
Medical School:	Saba University School of Medicine The Bottom, Saba, NETHERLANDS ANTILLES
Year of Grad:	2012
Degree Type:	MD

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Reported

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Section III

Identity

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

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

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

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

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

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.

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

WATSON
Applicant's **Printed** Last Name

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

AUGUST 27, 2014
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 27th day of August, 2014.

Notary Public Signature: Thomas Mavrey

My Notary Commission Expires: 10/16/18

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

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

315938

204019566

RECEIVED
SEP 05 2014
By

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: WATSON (Last) JENNIFER (First) MARIE (Middle)

FCVS ID Number: 315938

Notary – Please complete the section below:

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 presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 27th, of (Month) August, (Year) 2014.

Notary Public Signature: Thomas Mauer

Commission Expiration Date* (Month) 10 /(Day) 16 /(Year) 2018

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

Notary Stamp Here

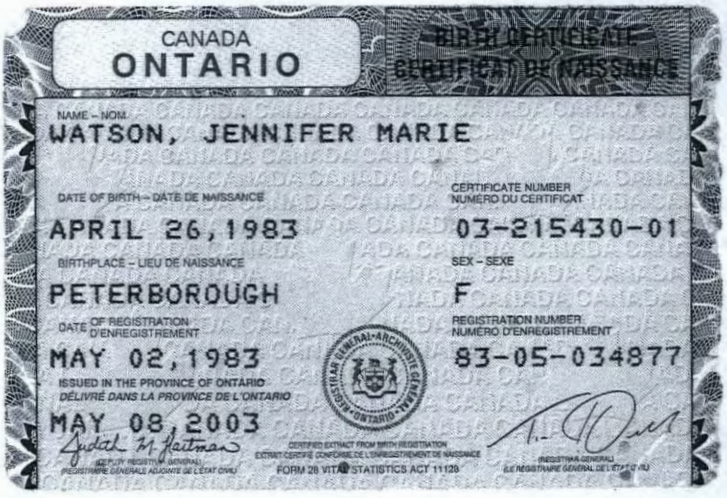
Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

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

SEAL VERIFIED

315938 BC PP

204019566



CANADA
ONTARIO

BIRTH CERTIFICATE
CERTIFICAT DE NAISSANCE

NAME – NOM
WATSON, JENNIFER MARIE

DATE OF BIRTH – DATE DE NAISSANCE
APRIL 26, 1983

CERTIFICATE NUMBER
NUMÉRO DU CERTIFICAT
03-215430-01

BIRTHPLACE – LIEU DE NAISSANCE
PETERBOROUGH

SEX – SEXE
F

DATE OF REGISTRATION
D'ENREGISTREMENT
MAY 02, 1983

REGISTRATION NUMBER
NUMÉRO D'ENREGISTREMENT
83-05-034877

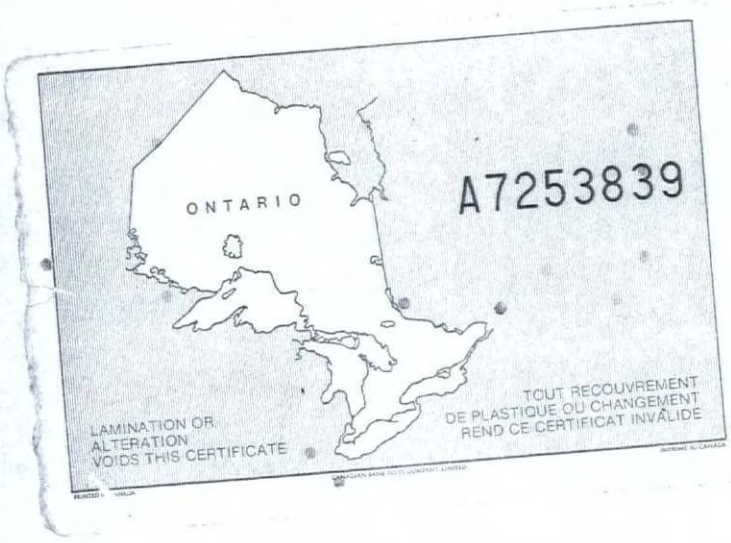
ISSUED IN THE PROVINCE OF ONTARIO
DÉLIVRÉ DANS LA PROVINCE DE L'ONTARIO
MAY 08, 2003

(DEPUTY REGISTRAR GENERAL)
(REGISTRAIRE GÉNÉRALE ADJOINTE DE L'ÉTAT CIVIL)

CERTIFIED EXTRACT FROM BIRTH REGISTRATION
EXTRAIT CERTIFIÉ CONFORME DE L'ENREGISTREMENT DE NAISSANCE
FORM 28 VITAL STATISTICS ACT 11129

(REGISTRAR GENERAL)
(LE REGISTRAIRE GÉNÉRAL DE L'ÉTAT CIVIL)

315938


ONTARIO
A7253839
LAMINATION OR
ALTERATION
VOIDS THIS CERTIFICATE
TOUT RECOUVREMENT
DE PLASTIQUE OU CHANGEMENT
REND CE CERTIFICAT INVALIDE

315938

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

Instructions 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
Suite 300
400 Fuller Wiser Road
Euless, TX 76039
or e-mail to:
fcvsforms@fsmb.org

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: Saba University School of Medicine

Address Line 1: The Church Street, PO Box 1000

Address Line 2:

City: The Bottom, Saba **State/Province:** Dutch Caribbean **ZIP Code (postal code):**

Country:

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: 15

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

Enrollment and Participation: Our records indicate that Watson, Jennifer Marie (type/print individual's name: Last, First, Middle, Suffix) attended our medical school for a total of 147 weeks of medical education on the following dates: From 09/01/2008 (Month Date Year) To 05/25/2012 (Month Date Year)

This individual:

Was awarded the degree of Doctor of Medicine on 05/25/2012 (Month Date Year)

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

Attestation

Affix Institutional Seal Here

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

SABA UNIVERSITY SCHOOL of MEDICINE — Saba

Watermark
For FCVS internal use only.

Print Name: Paula Boisseau

Signature: Paula Boisseau

Title: Registrar Date: 11 /04/ 2014

Tel: 978-862-9600 Fax: 978-8632-9699 E-mail: registrar@saba.edu

ELECTRONIC SEAL VERIFIED

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? YES ☐ NO X

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the Interruption/extension was approved or unapproved.

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
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 X

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

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 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 X

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 X

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

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? YES ☐ NO X

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

Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Jennifer Marie Watson

Saba 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: Jennifer Marie Watson

PROVIDED BY APPLICANT

SABA UNIVERSITY SCHOOL OF MEDICINE

TRANSCRIPT OF ACADEMIC RECORDS

P.O. BOX 1000, SABA, DUTCH CARIBBEAN

STUDENT NAME
Watson, Jennifer Marie

DEGREE(S) CONFERRED:
Doctor of Medicine 05/25/2012

STUDENT ID	PROGRAM	MATRICULATED AS OF:	DATE ISSUE:
518618970	**Medicine**	**09/01/2008**	**05/29/2012**

Fall 2008--SABA UNIVERSITY

SESSION DATES 09/01/2008 - 12/12/2008

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
MED 501 Gross & Developmental Anatomy	B	85	3.00	42.00	14.00
MED 502 Histology & Cell Biology	B	82	3.00	30.00	10.00
MED 505 Intro to Research Skills/EBM	P				3.00

	ATT	ERN	QPTS	GPA
CURRENT	24.00	27.00	72.00	3.00
CUMULATIVE	24.00	27.00	72.00	3.00

Winter 2009--SABA UNIVERSITY

SESSION DATES 01/05/2009 - 04/17/2009

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
MED 601 Biochemistry	B	81	3.00	30.00	10.00
MED 602 Physiology	B	84	3.00	30.00	10.00
MED 603 Medical Psychology	A	97	4.00	36.00	9.00
MED 604 Medical & Legal Ethics	A	94	4.00	16.00	4.00

	ATT	ERN	QPTS	GPA
CURRENT	33.00	33.00	112.00	3.39
CUMULATIVE	57.00	60.00	184.00	3.23

Summer 2009--SABA UNIVERSITY

SESSION DATES 05/04/2009 - 08/14/2009

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
MED 701 Microbiology & Immunology	B	84	3.00	36.00	12.00
MED 702 Neuroscience	B	81	3.00	27.00	9.00
MED 703 Medical Genetics	B	89	3.00	15.00	5.00
MED 704 Epidemiology & Prev Medicine	A	92	4.00	16.00	4.00

	ATT	ERN	QPTS	GPA
CURRENT	30.00	30.00	94.00	3.13
CUMULATIVE	87.00	90.00	278.00	3.20

Fall 2009--SABA UNIVERSITY

SESSION DATES 08/31/2009 - 12/11/2009

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
MED 801 Pharmacology	B	82	3.00	36.00	12.00
MED 802 Pathology I	C	79	2.00	22.00	11.00
MED 803 Physical Diagnosis	A	93	4.00	40.00	10.00

	ATT	ERN	QPTS	GPA
CURRENT	33.00	33.00	98.00	2.97
CUMULATIVE	120.00	123.00	376.00	3.13

ORIGINAL SEAL

BERNICE OUELLET UNIVERSITY REGISTRAR

SABA UNIVERSITY SCHOOL OF MEDICINE

TRANSCRIPT OF ACADEMIC RECORDS

P.O. BOX 1000, SABA, DUTCH CARIBBEAN

STUDENT NAME
Watson, Jennifer Marie

DEGREE(S) CONFERRED:
Doctor of Medicine 05/25/2012

STUDENT ID	PROGRAM	MATRICULATED AS OF:	DATE ISSUE:
518618970	**Medicine**	**09/01/2008**	**05/29/2012**

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
Spring 2010--SABA UNIVERSITY					
SESSION DATES 01/04/2010 - 04/16/2010					
MED 901 Intro to Clinical Medicine	B	83	3.00	30.00	10.00
MED 902 Clinical Pathology II	B	89	3.00	33.00	11.00
MED 903 Medical Board Review	P				10.00

	ATT	ERN	QPTS	GPA
CURRENT	21.00	31.00	63.00	3.00
CUMULATIVE	141.00	154.00	439.00	3.11

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
Third Year Clinical--SABA UNIVERSITY					
Internal Medicine	A				12.00
Obstetrics and Gynecology	B				6.00
Psychiatry	A				6.00
Surgery	A				12.00
Pediatrics	A				6.00
Total Weeks/Hours					42.00

DESCRIPTION	GRADE	SCORE	QUAL. UNITS	SEM. PTS	WEEKS/ HOURS
Fourth Year Clinical--SABA UNIVERSITY					
Anesthesiology	A				2.00
Family Medicine	A				6.00
IM Pulmonary Disease & Critical Care Med	A				4.00
Diagnostic Radiology	A				2.00
Psychiatry	A				4.00
IM Hematology and Oncology	A				4.00
Neurology	A				4.00
ENT Otolaryngology	A				4.00
Total Weeks/Hours					30.00

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

ORIGINAL SEAL

BERNICE OUELLET UNIVERSITY REGISTRAR

TRANSCRIPT IS VALID ONLY WHEN IT BEARS THE REGISTRAR'S SIGNATURE AND RAISED SEAL

TRANSCRIPT GUIDE PRINTED ON REVERSE

SABA UNIVERSITY SCHOOL OF MEDICINE

OFFICE OF THE REGISTRAR
27 Jackson Rd., Suite 301
Devens, MA 01434
Phone: 978.862.9600 * Fax: 978.862.9699

CAMPUS SITE
P.O. Box 1000
The Bottom, Saba
Dutch Caribbean

TRANSCRIPT KEY

CALENDAR:
The Basic Science program operates on the tri-semester schedule; Fall (September-December); Winter (January-April); Summer (May-August). The Clinical Medicine program operates under the calendar semester of 15 weeks in length. One credit represents one week of clinical rotations.

TRANSCRIPT SUMMARY:

SEM ATT:	Number of credits attempted in a semester.
ERN:	Number of credits passed. (A through C)
CUM ATT:	Cumulative number of credits attempted at S.U.S.M.
QPTS:	Quality points.
GPA:	Grade Point Average, QPTS divided by CUM TTL. Grade Point Average is not included in third and fourth year of M.D. Program.
*	Hyperbaric Medicine Courses

GRADING SYSTEM: BASIC SCIENCE, CLINICAL MEDICINE, AND HYPERBARIC MEDICINE PROGRAMS.
The following grades are included in the calculation of GPA.

A	90-100%	(Superior Performance)
B	80-89%	(Good, Commendable Performance)
C	75-79%	(Satisfactory Performance)
F	below 75%	(Unsatisfactory-Failing Performance)
WF		(Withdrawn/Failing) at the time of withdrawal

The following are not included in the calculation of GPA.

H	(Honors)
P	(Pass)
E	(Unsatisfactory-Failing Performance)
I	(Incomplete)
IP	(In Process)
W	(Withdrawal)
WP	(Withdrawn/Pass) passing at the time of withdrawal
T/C	(Transfer Credits) accepted.
SCHEDULED	(Approved clerkship) no grade awarded.
CURRENT	(Clerkship in progress) indicates weeks but not grade.
PENDING	(Clerkship completed) awaiting grade

STATUS:

DEANS LIST	Per recommendation by Dean – Prior Fall 1999 Fall 1999, GPA of 3.75 or greater. As of May 2003, GPA of 4.0
HONORS	Maintain a current GPA of 3.5 or greater. Fall 1999, GPA of 3.5 to 3.74. As of May 2003, 3.5 to 3.99.
GOOD STANDING	Maintain a current GPA of 2.0 to 3.49.
ACADEMIC PROBATION	Prior January 2007 - Below 2.0 GPA

REQUIREMENTS FOR BACHELOR OF SCIENCE DEGREE:
In order to qualify for the degree, a student must complete a minimum of 120 semester hours. The 120 semester hours may combine pre-medical coursework and courses taken in the Doctor of Medicine program at SUSOM. The student must maintain an academic average of "C" or better during their matriculation at SUSOM.

REQUIREMENTS FOR MASTER OF SCIENCE DEGREE:
Prior January 2007 - A total of 40 semester hours must be completed with at least a "C" average. A thesis is required to receive the M.S. degree. *Indicates coursework completed towards M.S. degree.
After January 2007 – Reference school catalog for curriculum requirements

REQUIREMENTS FOR THE DOCTOR OF MEDICINE DEGREE (M.D.):
For the M.D. degree the student must: (a) complete all the basic medical science coursework with an average of "C" or better, (b) complete a minimum of 72 weeks of clinical hospital rotations, and (c) be recommended by the Dean of Clinical Medicine for graduation. Effective August 2010: (d) successfully pass the USMLE Step I, Step 2CK and Step 2CS examinations.

Degree(s) conferred appear in upper right corner of text area.

CERTIFICATION OF OFFICIAL TRANSCRIPTS:
An official transcript is printed on secure paper requires a raised seal and bears the signature of the registrar. Copies issued directly to students will have "ISSUED TO STUDENT" stamped on the transcript.

NOTE: This transcript cannot be released to third party without written consent of the student.

Rev. 11.10.10

0-874-046-6

Saba University School of Medicine

in consideration of the satisfactory completion of all
requirements prescribed by the faculty
hereby confers upon

Jennifer Marie Watson

the degree of

Doctor of Medicine

together with all the rights, privileges and responsibilities appertaining thereto.
In testimony whereof, the corporate seal and the signatures as authorized
by the Board of Trustees are hereunto affixed.

Given at Saba, Dutch Caribbean
this twenty-fifth day of May, two thousand and twelve.

Examination Committee

Chairman, Board of Trustees

SABA UNIVERSITY SCHOOL of MEDICINE
MCMXCII
Saba

President, Saba University

ORIGINAL SEAL

5/29/12

3159938

Educational Commission for Foreign Medical Graduates

The ECFMG® certifies that

Jennifer Marie Watson

has successfully passed the required examinations, satisfied all the requirements of the Commission, and has been awarded this Certificate.

Steven E. Minnick MD
Chair, Board of Trustees

Emmanuel Papadakis M.D.
President and Chief Executive Officer

Certificate Number	0-874-046-6
Medical Science	
USMLE Step 1	June 10, 2010
USMLE Step 2 CK	July 18, 2011
Clinical Skills	
USMLE Step 2 CS	July 26, 2011

Date Issued June 4, 2012

ECFMG®
EDUCATIONAL COMMISSION FOR
FOREIGN MEDICAL GRADUATES

3624 Market St
Philadelphia, PA 19104-2685 USA
215-386-5900 | 215-386-3185 FAX
www.ecfmg.org

State Board Code:
036
Please include this number on all requests

OHIO STATE MEDICAL BOARD
EXECUTIVE DIRECTOR
c/o Federation Credentials Verification Service
30 E. BROAD STREET
3RD FLOOR
COLUMBUS, OH, 43215-6127

ECFMG® CERTIFICATION STATUS REPORT

USMLE™/ECFMG Identification Number: 0-874-046-6
Applicant's Name: Jennifer Marie Watson
Applicant's Date of Birth: 04/26/1983
ECFMG Certified:Yes
Certificate Issue Date: 06/04/2012
English Test Valid Through: Valid Indefinitely
Clinical Skills Assessment Valid Through: Valid Indefinitely

Passing Performance on Medical Science Examinations:

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	10 Jun 2010	*	*
USMLE Step 2 CK	18 Jul 2011	*	*

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
USMLE Step 2 CS	26 Jul 2011

Name of Medical School and Country:Saba University School of Medicine, The Bottom, SABA

Degree Year: 2012
† Medical Education Credentials Status: Complete
This information is reported directly from ECFMG computer records and is current as of 08/29/14.

How to Verify the Authenticity of this Report:

This report was issued to the named recipient on the date shown below. To verify the authenticity of this report, visit https://cvsonline2.ecfmg.org/verify/verify.aspx and enter the unique verification code at the bottom of the report. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.
* To obtain a complete history of and scores for USMLE Step examination(s) that may have been taken by this individual, contact the appropriate registration entity to request a USMLE transcript.

† Since July 1986, ECFMG has verified medical school credentials directly with the medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

Report Verification Code: FYDEV8SFQZ

Section V

Graduate 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 Graduate Medical Education

Federation of STATE MEDICAL BOARDS

Institution: Case Western Reserve University/University Hospitals Case Medical Center Program **Affiliated University:** Case Western Reserve University School of Medicne

Address Line 1: 11100 Euclid Avenue

Address Line 2: Bolwell 1200

Country: US **City:** Cleveland **State/Prov.:** OH **Zip Code:** 44106

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

Verification For: Watson, Jennifer Marie **Date of Birth:** April 26, 1983

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

Program Participation:

Important:

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

If the training level (years) 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 or Specialty is rotating or transitional, please provide a schedule of rotations.

Program Type			
R	**Training Level:** 0-1	**Specialty/Subspecialty:** Family Medicine	
	From: 07/01/2012	**To:** 06/30/2013	
	Successfully Completed? Yes		
	Accredited by: ACGME		
Program Type	**Training Level:** 1-2	**Specialty/Subspecialty:** Family Medicine	
R	**From:** 07/01/2013	**To:** 06/30/2014	
	Successfully Completed? Yes		
	Accredited by: ACGME		
Program Type	**Training Level:** 2-3	**Specialty/Subspecialty:** Family Medicine	
R	**From:** 07/01/2014	**To:** 06/30/2015	
	Successfully Completed?	In Progress	
	Accredited by: ACGME		

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 extension from his/her training?	No
If "Yes" provide start and end dates: **From:** **To:**	
2. Was this individual ever placed on probation?	No
3. Was this individual ever disciplined or placed under investigation?	No
4. Were any negative reports for behavioral reason ever filed by instructors?	No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	No

Please explain any "Yes" response from above:

Attestation

Affix Institutional Seal Here.

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

Watermark

For FCVS internal use only.

Completion attests the information above is an accurate account of this individual's records and is true and correct. Signature line must contain original signature or electronic typed signature of program director

Print Name: WandaCruz-Knight MD **MD/DO:** Yes

Signature: *Wanda Cruz-Knight MD*

Title: Program Director **Date:** 08/27/2014

Tel: (216) 844-5483 **Fax:** (216) 844-1030 **Email:** wanda.cruz-knight@uhhospitals.org

ELECTRONIC SEAL VERIFIED

345958 113065 204019566

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: Jennifer Marie Watson

University Hospitals Case Medical Center

Family Medicine

Unusual Circumstances

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

End of report for: Jennifer Marie Watson

PROVIDED BY APPLICANT

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

The Federation of State Medical Boards of the U.S., Inc.
Federation Credentials Verification Service
Federation Place
PO Box 619850
Dallas, TX 75261-9850
Tel: (817) 868–5000
Fax: (817) 868–5099

July 11, 2014

Attn: State Medical Board of Ohio
CME and Renewal Section
30 East Broad Street, 3rd Floor
Columbus, OH 43212

RE:Jennifer Watson
FCVS Packet ID: 315938

To Whom It May Concern::

The Medical Board you have designated has notified the Federation Credentials Verification Service (FCVS) the documentation that must be included in all Physician Information Profiles (Profile) sent to the Board. The attached Profile does not meet those requirements in the areas listed below:

- LMCC Licensure Examination

I have requested that FCVS forward my Physician Information Profile to your Board without the above verification.

Sincerely,

Jennifer M Watson	November 4th, 2014
Signature	Date

By providing my typed name in the space above, I certify that I am the person identified in this document and my typed name serves the same purpose as physically signing this document.

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date : **08/27/2014**

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 315938

Examinee: Watson, Jennifer Marie
Alt Name(s):

Examinee ID#: 0-874-046-6
Date of Birth: 04/26/1983

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	06/10/2010	Pass	238	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	07/18/2011	Pass	221	(189)	

Clinical Skills (CS)*

	Test Date	Pass/Fail	Total	MP	Comments
	07/26/2011	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
OHIO	03/04/2014	Pass	229	(190)	

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Examinee: Watson, Jennifer Marie

Examinee ID#: 0-874-046-6
Date of Birth: 04/26/1983

INTERPRETATION OF RESULTS

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

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

STEP 2 CLINICAL SKILLS (CS)

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

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

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

ANNOTATIONS APPEARING AS "NOTE"

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

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

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

4/2013

State Medical Board of Ohio

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

2/12/2015

Dr. Jennifer Marie Watson
1469 Black Pond Drive
Akron OH 44320

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **125670** was issued on **02/12/2015** and will expire on **10/01/2015**.

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

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

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

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

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

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

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

Sincerely,

Mitchell Alderson
Chief, Licensure

Date Posted: 8/24/2015 6:03:45 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

BUSINESS ADDRESS	Akron General Medical Center Green Primary Care 1940 Town Park Blvd Uniontown, OH 44685 Summit County United States of America 330-896-5010
CREDENTIAL MAIL ADDRESS	Akron General Medical Center Green Primary Care 1940 Town Park Blvd Uniontown, OH 44685 Summit County United States of America 330-896-5010 jennifer.watson@akrongeneral.org
CREDENTIAL MAIL ADDRESS	Akron General Medical Center Green Primary Care 1940 Town Park Blvd Uniontown, OH 44685 Summit County United States of America 330-896-5010 jennifer.watson@akrongeneral.org
MAIN	1469 Black Pond Drive Akron, OH 44320 Summit County United States of America (202) 340-3939 jenni889@hotmail.com

License Information

License Number	35.125670
License Name	Jennifer Watson

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other**

than failure to maintain records on a timely basis or to attend staff meetings?

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 40-44

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

. 0

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

. 5-9

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

. 0

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

. 1-4

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

. 1-4

Clinical - Practice setting

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

. 40-44

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

. 0

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 44685

2. Enter the first county:

. . . . . Summit

3. Enter the second zip code:

. 44307

4. Enter the second county:

. . . . . Summit

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

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

. . . . . 1940 Town Park Blvd, Uniontown, OH 44685; 1 Akron General Ave, Akron, OH 44307

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1154676948

DEA number

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

. . . . . FW5061673

OARRS Registration

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

. . . . . NO

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

. . . . . YES

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

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

Date Posted: 4/18/2017 8:07:52 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

BUSINESS ADDRESS	Cleveland Clinic - Akron General Green Primary Care 1946 Town Park Blvd Suite 200 Uniontown, OH 44685 Summit County United States 330-896-5010
CREDENTIAL MAIL ADDRESS	Cleveland Clinic - Akron General Green Primary Care 1946 Town Park Blvd Suite 200 Uniontown, OH 44685 Summit County United States 330-896-5010 jennifer.watson@akrongeneral.org
MAIN	1469 Black Pond Drive Akron, OH 44320 Summit County United States (202) 340-3939 jmwatson426@gmail.com

License Information

License Number	35.125670
License Name	Jennifer Watson

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . YES

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

. . . . . Heather Brianna Spuhler, CNP; Leigh Ann Gratz, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 45-49

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

. 0

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

. 0

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

. 0

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

. 0

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

. 0

Clinical - Practice setting

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

. 45-49

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

. 0

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 44685

2. Enter the first county:

. . . . . Stark

3. Enter the second zip code:

. 44223

4. Enter the second county:

. . . . . Summit

5. Enter the third zip code:

. 44307

6. Enter the third county:

. . . . . Summit

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

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

. . . . . 1946 Town Park Blvd Suite 200, Uniontown, Ohio, 44685; 1 Akron General Avenue, Akron, Ohio, 44307; 2127 State Street, Cuyahoga Falls, Ohio, 44223

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1154676948

DEA number

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

. . . . . FW5061673

OARRS Registration

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

. . . . . YES

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

. . . . . YES

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

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

Contact Audit Trail for WATSON JENNIFER

Date	User	Table	Field	New	Old
4/19/2017 7:13:43 AM	Hawk, L	CONTACTADDRESS	ADDRESS3	1946 Town Park Blvd Suite 200	1940 Town Park Blvd
4/19/2017 7:13:43 AM	Hawk, L	CONTACTADDRESS	ADDRESS3	1946 Town Park Blvd Suite 200	1940 Town Park Blvd
4/19/2017 7:13:42 AM	Hawk, L	CONTACTADDRESS	ADDRESS1	Cleveland Clinic - Akron General	Akron General Medical Center
4/19/2017 7:13:42 AM	Hawk, L	CONTACTADDRESS	ADDRESS1	Cleveland Clinic - Akron General	Akron General Medical Center
1/3/2017 1:17:30 PM	Rieve, K	CONTACTADDRESS	ADDRESS3		1940 Town Park Blvd
1/3/2017 1:17:30 PM	Rieve, K	CONTACTADDRESS	ADDRESS1	1940 Town Park Blvd	Akron General Medical Center
1/3/2017 1:17:30 PM	Rieve, K	CONTACTADDRESS	ADDRESS2		Green Primary Care
1/3/2017 1:17:30 PM	Rieve, K	CONTACTADDRESS	COMPANY	Akron General Medical Center Green Primary Care	
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States of America	
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States of America	
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States of America	
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States of America	
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	COUNTYID	Summit	Cuyahoga
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	COUNTYID	Summit	Cuyahoga
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ADDRESS3	1940 Town Park Blvd	
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ADDRESS3	1940 Town Park Blvd	11100 Euclid Avenue
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ADDRESS3	1940 Town Park Blvd	11100 Euclid Avenue
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	PHONE	330-896-5010	(202) 340-3939
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	PHONE	330-896-5010	
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	PHONE	330-896-5010	
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	CITY	Uniontown	Akron
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	CITY	Uniontown	Cleveland
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	CITY	Uniontown	Cleveland
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ZIPCODE	44685	44320
8/24/2015	Bates, J	CONTACTADDRESS	ZIPCODE	44685	44106

5:09:46 PM					
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ZIPCODE	44685	44106
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ADDRESS1	Akron General Medical Center	1469 Black Pond Drive
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ADDRESS1	Akron General Medical Center	University Hospitals Case Medical Center
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ADDRESS1	Akron General Medical Center	University Hospitals Case Medical Center
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ADDRESS2	Green Primary Care	
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ADDRESS2	Green Primary Care	Office of GME-Lakeside 6223-C
8/24/2015 5:09:46 PM	Bates, J	CONTACTADDRESS	ADDRESS2	Green Primary Care	Office of GME-Lakeside 6223-C
1/21/2015 9:17:09 AM	Mack, C	CONTACT	TITLE	Dr.	
1/21/2015 9:17:09 AM	Mack, C	CONTACT	TAXID	[redacted]	
1/14/2015 3:39:41 PM	Adams, B	CONTACTADDRESS	CITY	Akron	Cleveland
1/14/2015 3:39:41 PM	Adams, B	CONTACTADDRESS	ZIPCODE	44320	44106
1/14/2015 3:39:41 PM	Adams, B	CONTACTADDRESS	COMMENTS		
1/14/2015 3:39:41 PM	Adams, B	CONTACTADDRESS	COUNTYID	Summit	Cuyahoga
1/14/2015 3:39:21 PM	Adams, B	CONTACTADDRESS	ZIPCODE	44320	44106
1/14/2015 3:39:21 PM	Adams, B	CONTACTADDRESS	COUNTYID	Summit	Cuyahoga
1/14/2015 3:39:21 PM	Adams, B	CONTACTADDRESS	CITY	Akron	Cleveland
1/14/2015 3:38:19 PM	Adams, B	CONTACTADDRESS	ADDRESS2		Apt #302
1/14/2015 3:38:19 PM	Adams, B	CONTACTADDRESS	CITY	Cleveland	Cleveland Heights
1/14/2015 3:38:19 PM	Adams, B	CONTACTADDRESS	PHONE	(202) 340-3939	
1/14/2015 3:38:19 PM	Adams, B	CONTACTADDRESS	COUNTYID	Cuyahoga	
1/14/2015 3:38:19 PM	Adams, B	CONTACTADDRESS	ADDRESS1	1469 Black Pond Drive	2489 Overlook Road
10/26/2012 9:39:10 AM	Bouldware, G	CONTACT	BIRTHCITY	Peterborough	
10/26/2012 9:39:10 AM	Bouldware, G	CONTACT	BIRTHSTATE	ON	
10/26/2012 9:39:10 AM	Bouldware, G	CONTACT	GENDER	F	
10/26/2012 9:39:10 AM	Bouldware, G	CONTACT	DATEOFBIRTH	19830426	

10/26/2012 9:38:53 AM	Bouldware, G	CONTACTADDRESS	ADDRESS1	2489 Overlook Road	
10/26/2012 9:38:53 AM	Bouldware, G	CONTACTADDRESS	ADDRESS2	Apt #302	
10/26/2012 9:38:53 AM	Bouldware, G	CONTACTADDRESS	CITY	Cleveland Heights	
10/26/2012 9:38:53 AM	Bouldware, G	CONTACTADDRESS	ZIPCODE	44106	
6/18/2012 12:15:20 PM	Bouldware, G	CONTACTADDRESS	ADDRESS1	University Hospitals Case Medical Center	
6/18/2012 12:15:20 PM	Bouldware, G	CONTACTADDRESS	ADDRESS2	Office of GME-Lakeside 6223-C	
6/18/2012 12:15:20 PM	Bouldware, G	CONTACTADDRESS	CITY	Cleveland	
6/18/2012 12:15:20 PM	Bouldware, G	CONTACTADDRESS	ZIPCODE	44106	
6/18/2012 12:15:20 PM	Bouldware, G	CONTACTADDRESS	ADDRESS3	11100 Euclid Avenue	
6/18/2012 12:15:20 PM	Bouldware, G	CONTACTADDRESS	COUNTYID	Cuyahoga	
6/15/2012 10:49:42 AM	Dillard, P	CONTACT	OLRPASSWORD	*******	*******