146995

State Medical Board of Ohio

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

Ohio Physician Licensure Application

1. ***Indicate License Type*** (X) 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
Katsuki	Monique	Yoder	

Maiden Name: Betty Monique Yoder

All other names used: Betty Monique Munsch

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

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

Practice Address

Street 1: | Phone Number:

Street 2: | Fax Number:

City: | State: | Zip Code: | email:

Home Address

Street 1: 6437 Westminster Drive | Phone Number: 605-670-3746

Street 2: | Fax Number:

City: Cleveland | State: OH | Zip Code: 44129 | email: yodermonique@gmail.com

4. ***Identification***

Date of birth	Birth City	State	Country
09/02/1979	Wooster	OH	

SSN: REDACTED

Gender: ( ) Male (X) 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.

Kitsuki

PC# 133581

OK MA 4/7/14

5. Preliminary Education.

High School or equivalent: Sunnyside High School

City: Sunnyside State: WA Country: USA

Date From: Aug 1993 Date To: June 1997

Undergraduate College 1: Washington State University

City: Pullman State: WA Country: USA

Date From: Aug 1997 Date To: Dec 1998 Degree: None

Undergraduate College 2: South Dakota State University

City: Brookings State: SD Country: USA

Date From: Aug 2001 Date To: May 2004 Degree: BSN

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 after 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.

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

Program Name: Cleveland Clinic Foundation - OB/Gyn

8. Military.

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

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

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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: University of South Dakota — Date From: 08/2008
Address: 1400 W. 22nd St. — Date To: 05/2012
City: Sioux Falls — State: SD — Zip Code: 57105 — Graduation Date: 05/04/2012
Country: USA — Degree: MD

2. School Name: — Date From:
Address: — Date To:
City: — State: — Zip Code: — Graduation Date:
Country: — 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: Cleveland Clinic — Date From: June 2012
Address: 9500 Euclid Ave / -181 — Date To: Current
City: Cleveland — State: OH — Zip Code:
Country: USA — Successfully Completed? ○ Yes ○ No
Department/Specialty: OB/Gyn
PGY ○ 1 ○ 2 ○ 3 ☒ 4 ○ 5 ○ other
PGT ○ Internship ☒ Residency ○ Fellowship ○ Research ○ other

2. 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

3. 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

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	09/2010	✓ Pass ○ Fail	1
USMLE Step 2 CS	2/2011	✓ Pass ○ Fail	1
USMLE Step 3		✓ 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		○ Pass ○ Fail	
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 | Issue Date

School Name | Date From
Address | Date To
City | State | Zip Code | Graduation Date
Country | Degree

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	Training	57.021543	(•) Active	( ) Inactive	6/2015
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 (X) 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* ____ *Year* ____

TO: *Month* ____ *Year* ____

◯ In Progress

Activity/Employer Name *(Non-Working*)* ____

Activity Address ____

City ____ State ____ Zip Code ____

Position / Department ____

Percent Clinical ____ Percent Administrative ____

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

____

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

FROM: *Month* ____ *Year* ____

TO: *Month* ____ *Year* ____

◯ In Progress

Activity/Employer Name *(Non-Working*)* ____

Activity Address ____

City ____ State ____ Zip Code ____

Position / Department ____

Percent Clinical ____ Percent Administrative ____

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

____

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

FROM: *Month* ____ *Year* ____

TO: *Month* ____ *Year* ____

◯ In Progress

Activity/Employer Name *(Non-Working*)* ____

Activity Address ____

City ____ State ____ Zip Code ____

Position / Department ____

Percent Clinical ____ Percent Administrative ____

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

____

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

FROM: *Month* / *Year*

TO: *Month* / *Year* / ○ In Progress

Activity/Employer Name *(Non-Working*)*

Activity Address

City | State | Zip Code

Position / Department

Percent Clinical | Percent Administrative

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

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

FROM: *Month* / *Year*

TO: *Month* / *Year* / ○ In Progress

Activity /Employer Name *(Non-Working*)*

Activity Address

City | State | Zip Code

Position / Department

Percent Clinical | Percent Administrative

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

16. *Malpractice:* *List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please provide a detailed written description of the background and medical issues involved in each case. Attach additional sheets if necessary.*

Name of patient involved: | State action took place

Name of Court | Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: | Amount paid on your behalf

Month and Year of incident | Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

Name of patient involved: | State action took place

Name of Court | Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: | Amount paid on your behalf

Month and Year of incident | Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

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.

This form must be completed if you have responded yes to Additional Information Question #I5 and/or #16.
Make additional copies of this form as needed.

Name of applicant _____ Date of incident _____

Location of Incident (City / State) _____

Were you arrested:
○ Yes ○ No

If the incident was alcohol-related, did you submit to a breath, blood, urine or other test to determine the amount of alcohol in your body?

If Yes, type if test and result _____

What offense(s) were you charged with? _____

Were the charges amended?:
○ Yes ○ No

If Yes, what were the final charges _____

Disposition:
○ Pending ○ Charges Dismissed ○ Charges Dropped ○ Conviction
○ Plea _____
○ Other _____

You must provide a detailed written explanation of the event including a description of the event, what led up to the event and what was learned. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach a separate sheet. Submit copies of the police report/arrest record, a copy of the charges or ticket, a copy of the final court disposition and any other relevant documentation.

To Mail you application:

You cannot save data typed into this form. Please print 2 copies of your completed form. Keep one copy for your records and mail the other copy to:

State Medical Board of Ohio
30 E. Broad Street, 3rd Floor
Columbus, Ohio 43215

COPY A
FOR CLERK OF COURT

Margin reserved for binding

Please use black ribbon in typewriter or black unfading ink. This is a permanent record.

COMMONWEALTH OF VIRGINIA

MARRIAGE REGISTER

CIRCUIT COURT FOR CITY OR COUNTY OF: MATHEWS

CLERK'S NUMBER: 15-24

PARTY A (check one) ☐ BRIDE ☒ GROOM ☐ SPOUSE

1. FULL NAME (first) (middle) (last) (suffix)	MAIDEN SURNAME (If different from last)
GLENN FOSTER KATSUKI	

2. SEX	3. AGE	4. DATE OF BIRTH (Month, Day, Year)	5. PLACE OF BIRTH (state or foreign country)	6. (DO NOT WRITE IN THIS SPACE)
M	38	09/02/1977	TEXAS	

7. RACE	8. NUMBER OF THIS MARRIAGE (first, second, etc.)	9. MARITAL STATUS (If previously married)
WHITE	SECOND	☐ WIDOWED ☒ DIVORCED

10. EDUCATION (Specify only highest grade completed)	Elementary or Secondary (0-12)	College (1-4 or 5+)	11. USUAL RESIDENCE: STREET ADDRESS OR RT. NUMBER
	12	5	6437 WESTMINSTER DRIVE

11a. CITY OR TOWN OF RESIDENCE	11b. County (If independent city, leave blank)	11c. STATE (OR FOREIGN COUNTRY)
PARMA	CUYAHOGA	OHIO

12. NAME OF PARENT (first, middle, last, suffix) (maiden name if any)	12a. SEX	13. NAME OF PARENT (first, middle, last, suffix) (maiden name if any)	13a. SEX
PAUL (NMN) KATSUKI	M	NANCY LEE BROOKS	F

PARTY B (check one) ☒ BRIDE ☐ GROOM ☐ SPOUSE

14. FULL NAME (first) (middle) (last) (suffix)	MAIDEN SURNAME (If different from last)
MONIQUE YODER KATSUKI	YODER

15. SEX	16. AGE	17. DATE OF BIRTH (Month, Day, Year)	18. PLACE OF BIRTH (state or foreign country)	19. (DO NOT WRITE IN THIS SPACE)
F	36	09/02/1979	OHIO	

20. RACE	21. NUMBER OF THIS MARRIAGE (first, second, etc.)	22. MARITAL STATUS (If previously married)
WHITE	SECOND	☐ WIDOWED ☒ DIVORCED

23. EDUCATION (Specify only highest grade completed)	Elementary or Secondary (0-12)	College (1-4 or 5+)	24. USUAL RESIDENCE: STREET ADDRESS OR RT. NUMBER
	12	5	6437 WESTMINSTER DRIVE

24a. CITY OR TOWN OF RESIDENCE	24b. County (If independent city, leave blank)	24c. STATE (OR FOREIGN COUNTRY)
PARMA	CUYAHOGA	OHIO

25. NAME OF PARENT (first, middle, last, suffix) (maiden name if any)	25a. SEX	26. NAME OF PARENT (first, middle, last, suffix) (maiden name if any)	26a. SEX
ALVIN E. YODER	M	LUCINDA KAY MASTERS	F

MARRIAGE LICENSE

27. TO ANY PERSON LICENSED TO PERFORM MARRIAGES
You are hereby authorized to join the above-named persons in marriage under procedures outlined in the statutes of the Commonwealth of Virginia.

Date Issued 09/21/2015
License Expires Sixty Days After Above Date

Signature [signature] Clerk of Court or Deputy

Date Received by Clerk of Court from Officiant 09/22/2015

TO OFFICIANT:

Complete and sign certificate on both copies

Return both copies within five days to Clerk of Court issuing license

Section 32.1-267 Code of Virginia

MARRIAGE CERTIFICATE

28. DATE OF MARRIAGE (Month, Day, Year)	29. PLACE OF MARRIAGE (county or independent city)	30. TYPE OF CEREMONY
9/21/2015	Mathews	☐ CIVIL ☒ RELIGIOUS

31. I CERTIFY THAT I JOINED THE ABOVE NAMED PERSONS IN MARRIAGE ON THE DATE AND AT THE PLACE SPECIFIED

SIGNATURE OF OFFICIANT [signature] TITLE OF OFFICIANT Reverend

Authorized to perform marriages by the Circuit Court for Suffolk (city or county), Virginia, in 2004 (year of authorization)

NAME OF OFFICIANT (type or print) Lisa R. Blackmonson

ADDRESS OF OFFICIANT 110 Linden Avenue (street or route number) Cobbs Creek (city or town) VA (state)

V53 7/15

A COPY TESTE:
ANGELA C. INGRAM, CLERK
BY: [signature]
DEPUTY CLERK

State Medical Board of Ohio

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

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.

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

Katsuki
Applicant's Printed Last Name

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

March 24, 2016
Date of Signature

Notary Public Signature

10/18/18
Date Commission Expires

Subscribed and sworn to before me on this 24th day of March ,20 16

NICOLE McKEAN
Notary Public, State of Ohio
My Comm. Expires 10-18-2018

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for

Name: **Monique Yoder Katsuki**

Social Security Number: REDACTED

Date of Birth: **September 02, 1979**

FID#: **215818592**

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: **Monique Yoder Katsuki**
Date of Birth: **September 02, 1979**
Social Security Number: REDACTED
FID: **215818592**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

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

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

University Of South Dakota School Of Medicine
1. Medical Education Form and Translation
2. Medical Education Dean's Letter
3. Medical Education Transcript and Translation
4. Medical Education Diploma and Translation

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Cleveland Clinic
1. GME Form

VI. Licensure Examination History

A. FSMB Exam Transcript

End of report for: Monique Yoder Katsuki

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Table of Contents

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

Section I

FCVS Reports

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name: **Monique Yoder Katsuki**

Documentation: Photocopy of Name Change Document and Translation if not in English

Variation of Name: **Betty Monique Yoder**

Documentation: Certified Birth Certificate OR Copy w/ Cert. of Identification

Betty Monique Munsch

Documentation: Photocopy of Divorce Decree and Translation if not in English

Gender: Female

Date of Birth: September 02, 1979

Place of Birth: OH, UNITED STATES

Social Security Number: REDACTED

FID: 215818592

Physical Description:
Height: 5 ft. 4 in.
Weight: 155 lbs.
Eye Color: Brown
Hair Color: Brown

Contact Information

Mailing Address:
6437 WESTMINSTER DR
CLEVELAND, OH 44129-4945
UNITED STATES

Permanent Address:
6437 WESTMINSTER DR
CLEVELAND, OH 44129-4945
UNITED STATES

Telephone Numbers:
Primary: (605) 670-2746
Secondary: N/A
Fax: N/A
Other: N/A

Pre-medical Education

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

Institution: **South Dakota State University**
Address: Brookings, SD 57007
UNITED STATES
Dates of Attendance: 08/--/2001 To 05/--/2004
Degree Conferred/Issued: Bachelor of Science

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **University Of South Dakota School Of Medicine**
Address: 1400 West 22nd
Sioux Falls, SD 57105-1570
UNITED STATES

Dates of Attendance: 08/04/2008 to 05/04/2012
Date Certificate Issued: 05/04/2012
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: **Cleveland Clinic**
Address: 9500 Euclid Avenue, A81

Cleveland, OH 44195
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/2012 To 06/30/2013
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/2013 To 06/30/2014
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 3
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/2014 To 06/30/2015
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 4
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/2015 To 06/30/2016
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: 09/2011	Passed the Exam
FSMB Transcript USMLE Step 2 CS	Date: 12/2011	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 06/2013	Passed the Exam

Board Action

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

End of report for: Monique Yoder Katsuki FID: 215818592

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:	**Monique Yoder Katsuki**
Date of Birth:	**September 02, 1979**
Social Security Number:	REDACTED
FID:	**215818592**

Omissions

There are no omissions identified.

Discrepancies

There are no discrepancies identified.

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Monique Yoder Katsuki

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: **Monique Yoder Katsuki**
Date of Birth: **September 02, 1979**
Social Security Number: REDACTE
FID#: **215818592**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
08/2008	05/2012	Medical Education Record	University Of South Dakota School Of Medicine,1400 West 22nd Sioux Falls, SD 57105-1570 UNITED STATES		
06/2012	06/2016	GME Record	Cleveland Clinic,9500 Euclid Avenue, A81 Cleveland, OH 44195 UNITED STATES		

End of report for: Monique Yoder Katsuki

Section II

FSMB and Other Reports

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PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:4/6/2016

PRACTITIONER INFORMATION

Name:	Betty Monique Yoder
DOB:	9/2/1979
Medical School:	University of South Dakota School of Medicine Vermillion Sioux Falls, South Dakota, UNITED STATES
Year of Grad:	2012
Degree Type:	MD
NPI:	1366708950

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:4/6/2016
Practitioner Name:	Betty Monique Yoder	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

Section III

Identity

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

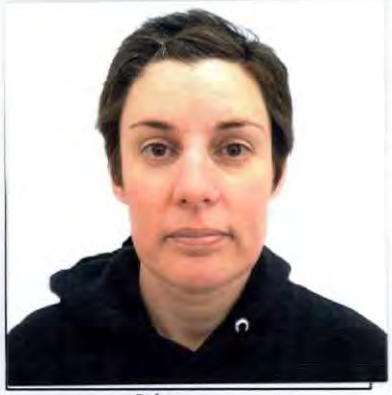
I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect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

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

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

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

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



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

Katsuki
Applicant's **Printed** Last Name

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

March 26, 2016
Date of Signature (**must** correspond to date of notarization)

NOTARY PUBLIC STATE OF OHIO

NICOLE McKEAN
Notary Public, State of Ohio
My Comm. Expires 10-18-2018

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 26th day of March, 2016.

Notary Public Signature: [signature]

My Notary Commission Expires: 10/18/18

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

359727

215818592

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Katsuki (Last) Monique (First) Yoder (Middle)

FCVS ID Number: 359727

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) 26th, of (Month) March, (Year) 2016.

Notary Public Signature: [signature]

Commission Expiration Date* (Month) October /(Day) 18 /(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

NOTARY PUBLIC STATE OF OHIO

NICOLE McKEAN
Notary Public, State of Ohio
My Comm. Expires 10-18-2018

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

359727 BC

215818592

VERIFY PRESENCE OF ODH WATERMARK HOLD TO LIGHT TO VIEW

STATE OF OHIO
OFFICE OF VITAL STATISTICS

CERTIFICATION OF BIRTH

STATE FILE NUMBER	1979116518	**DATE RECORD FILED**	09/10/1979
NAME	BETTY MONIQUE YODER		
DATE OF BIRTH	09/02/1979	**SEX**	FEMALE
BIRTHPLACE	OHIO		
MOTHER'S NAME	LUCINDA KAY YODER	**FATHER'S NAME**	ALVIN E YODER
MAIDEN NAME	MASTERS		
MOTHER'S BIRTHPLACE	OHIO	**FATHER'S BIRTHPLACE**	OHIO

Note:

This is a true certification of the name and birth facts as recorded in the Office of Vital Statistics, Columbus, Ohio. Witness my signature and seal of the Department of Health this 19 day of November, 2015

Judith B Nagy

State Registrar of Vital Statistics

H4508975

WAYNE CO HEALTH DEPT

359727

SEAL VERIFIED

REV. 6/2009

VOID WITHOUT WATERMARK OR IF ALTERED OR ERASED

VERIFY PRESENCE OF ODH WATERMARK HOLD TO LIGHT TO VIEW

STATE OF SOUTH DAKOTA)
)SS:
COUNTY OF TURNER)

IN CIRCUIT COURT

FIRST JUDICIAL CIRCUIT

****

JAY D. MUNSCH,
Plaintiff,

vs.

BETTY M. MUNSCH
Defendant.

DIV. # 08-05

JUDGMENT AND DECREE OF DIVORCE

****

The above entitled matter having come on before this Court, pursuant to the foregoing Stipulation and Agreement, and the parties and the Court having been advised that the parties have resolved all of the issues in the pending matter, and the Court having reviewed the Stipulation and Agreement executed by both parties; and the Court having reviewed the Affidavits of Irreconcilable Differences which are executed by the parties and which were filed with the Court; and the Court having reviewed the pleadings on file herein, as well as applicable statutes and case law; and the Court having been advised the neither party is a member of the Armed Services of the United States of America, and good cause appearing, therefore, it is hereby

ORDERED, ADJUDGED, AND DECREED that the marital bonds heretofore existing between Jay D. Munsch, Plaintiff, and Betty M. Munsch, Defendant, be and are hereby dissolved; it is further

ORDERED, ADJUDGED, AND DECREED that the Stipulation and Agreement is hereby adopted by the Court and is hereby incorporated herein as a full and complete adjustment of the property and obligations of the parties hereto; and it is further

ORDERED, ADJUDGED, AND DECREED that the Plaintiff and Defendant are granted a divorce from each other on the grounds of irreconcilable differences; and it is further

ORDERED, ADJUDGED, AND DECREED that the Plaintiff, Jay D. Munsch, shall be awarded the personal property currently in his possession; and it is further

ORDERED, ADJUDGED, AND DECREED that the Defendant, Betty M. Munsch, shall be awarded the personal property currently in her possession; and it is further

ORDERED, ADJUDGED, AND DECREED that neither party shall pay alimony to the other; and it is further

ORDERED, ADJUDGED, AND DECREED that each of the parties shall be responsible for his or her own attorney fees, sales tax, and costs incurred herein; and it is further

ORDERED, ADJUDGED, AND DECREED that the Defendant's name be changed to Betty M. Yoder.

Dated this 29th day of April, 2008.

By the Court:

Timothy Bjorkman
Circuit Court Judge

ATTEST:

Colleen Dunn
Clerk of Courts
By Kris A Pluecker Deputy

STATE OF SOUTH DAKOTA
First Judicial Circuit Court
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on file in my office on this date:

MAY 05 2008

Colleen Dunn
Turner County Clerk of Courts
By: Kris A Pluecker Deputy

PROBATE COURT OF CUYAHOGA COUNTY, OHIO

ANTHONY J. RUSSO, PRESIDING JUDGE
LAURA J. GALLAGHER, JUDGE

IN THE MATTER OF
THE CHANGE OF NAME OF:
BETTY MONIQUE YODER
To **MONIQUE YODER KATSUKI**

Case No: **2015 MSC 212221**

JUDGMENT ENTRY

CHANGE OF NAME OF ADULT

On **JANUARY 13, 2016** an Application for Change of Name was heard by this Court. The Court finds that proper notice of the Application and hearing date was given by one publication in a newspaper of general circulation in this county at least thirty days prior to the hearing on the Application. The Court further finds that reasonable and proper cause exists for changing the name. The Court finds that the Applicant's complete name at birth was **BETTY MONIQUE YODER**; Applicant's date of birth is **SEPTEMBER 02, 1979**, and the place of birth is **WOOSTER, WAYNE COUNTY, OHIO, U.S.A.**

Therefore, it is **ORDERED** that the name of **BETTY MONIQUE YODER** be changed to **MONIQUE YODER KATSUKI**.

JUDGE ANTHONY J. RUSSO

CERTIFICATION OF JUDGMENT ENTRY

The above Judgment Entry - Change of Name of Adult is a true copy of the original kept by me as custodian of the records of this Court.

ANTHONY J. RUSSO, PRESIDING JUDGE

By:

Deputy Clerk

JAN 19 2016

Date

ISSUED 01/19/2016 10:56:27 BY: MXB
FORM 21.1 - JUDGMENT ENTRY - CHANGE OF NAME OF ADULT

(11/01/2000)

359727

Section IV

Medical Education

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

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

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

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

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

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

Institution Name: University Of South Dakota School Of Medicine

Address Line 1: Lee Medical Building Room 101

Address Line 2: 414 East Clark Street

City: Vermillion **State/Province:** SD **Zip Code (Postal Code):** 57069

Country: US

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

Premedical Education:
Years of education required for admission to your medical school: 2
Credential/degree presented by the applicant for admission to your medical school: BS South Dakota State University

Enrollment and Participation: Our records indicate that Katsuki, Monique Yoder
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 4 years of medical education on the following dates: **From:** 08/04/2008 (Month Day Year) **To:** 05/04/2012 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 05/04/2012 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

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

Watermark
For FCVS internal use only.

Name: Kay Austin

Signature: *Kay L. Austin*

Title: Medical Registrar Officer
Date of Signature: 03/16/2016 **Phone:** (605) 658-6304
Fax: (605) 677-5109 **Email:** Kay.Austin@usd.edu

ELECTRONIC SEAL VERIFIED

669 12 2194 215818592

Unusual Circumstances

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

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

	From Date:	**To Date:**
Personal/Family_____		
Academic remediation_____		
Health _____		
Financial _____		
Participation in joint degree Program (e.g., MD/PhD)		
Participation in non-research special study		
(e.g., fellowship, international experience)_____		
Participation in non-degree research _____		
Other:		
Other:		

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? **No**

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

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

Please specify a reason:

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

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

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

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

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

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

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Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Monique Yoder Katsuki

University Of South Dakota 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: Monique Yoder Katsuki

PROVIDED BY APPLICANT

SANFORD SCHOOL OF MEDICINE
The University of South Dakota

MEDICAL STUDENT AFFAIRS
414 East Clark Street
Vermillion, SD 57069-2390
605-677-5233 • 605-677-5109 fax
www.usd.edu/md

MEDICAL STUDENT PERFORMANCE EVALUATION
(Betty) Monique Yoder
November 1, 2011

IDENTIFYING INFORMATION

(Betty) Monique Yoder is currently enrolled as a fourth year student in good standing at the Sanford School of Medicine of the University of South Dakota. The Sanford School of Medicine (SSOM) provides Basic Biomedical Science training at the Vermillion campus, and Clinical training at one of three campuses located in Sioux Falls, Yankton or Rapid City. Monique received her clinical training at the Yankton campus.

UNIQUE CHARACTERISTICS

Monique completed a BS degree at South Dakota State University, graduating Cum Laude in May, 2004 with a major in Nursing. She then worked in the nursing profession until matriculating into medical school. During her premedical years she was awarded the Spirit of Jesse Award at the University based on nominations by peers as the student who best exemplified kindness, compassion, generosity, and loving care of patients. She volunteered with Habitat for Humanity, and worked at an assisted living center while completing her nursing degree. As a nurse, she provided diabetes education and conducted a foot care clinic. She also worked in cardiovascular rehabilitation, became the Cardiac Rehabilitation Coordinator, and was editor for the regional Cardiovascular Rehabilitation Association Newsletter.

While in medical school, Monique has attained several scholarships including the John Howe, the Ernest & Mina Walkes, the Sanford School of Medicine, and the Gisness Family scholarships for her academic achievements. She was also selected for one of the Avera Sacred Heart scholarships for students training on the Yankton Campus who show great promise in clinical practice.

Monique has contributed to the operations of the medical school through service on the Pathology Focus Group. She assisted with the program to set up practice lab exams for the first year students. She has also volunteered with the Welcome Table for those in the community in need of a meal, and gave an STD talk at a nearby high school. She was one of the students who participated in the voluntary Medical Spanish program.

During the summer between her first and second year, Monique participated in a newly developed internship in Yankton whereby students have the opportunity to work with physicians in the clinic to learn about the basics of assessment and management in patient care.

During the third year, Monique participated in a community based cultural diversity outreach program which involved teaching immigrants and refugees in a social services program to provide information on good nutrition and the foods available in the United States. She also learned about the other services available to this population of individuals. The poster she presented to describe this experience was one of the few selected for presentation at the South Dakota State Medical Association annual meeting.

ACADEMIC HISTORY

Monique matriculated in August, 2008 and should complete all the requirements for the M.D. degree on the standard schedule by May, 2012. Her academic performance has been outstanding, achieving yearly grade point averages of 4.00, 3.97, and 4.00. A cumulative average of 3.99 ranks her 5/51 students at the completion of the 3rd year.

Monique passed USMLE Step 1 in June, 2010 and Step 2-CK in September, 2011. She also passed the Sanford School of Medicine OSCE in July, 2011.

There have been no cases of remediation/repetition of coursework, nor have there been cases of adverse action by the medical school or by the University of South Dakota.

ACADEMIC PROGRESS

On a scale of "Marginal – Acceptable – Good – Exceptional", the Basic Biomedical Science faculty rated Monique's performance as Acceptable to Good with some Exceptional ratings for her 'Learning Attitude'. Narrative comments included "...good leadership qualities...serious about learning and eager to apply the basic science to her knowledge about clinical care...did very well in the course [Pathology]...she is committed to doing her best...worked hard to make material apply to clinical medicine..." For her Physical Diagnosis class, the physician comments included "...very sincere...trustworthy...a great clinical student – in fact she's exceptional..."

During a four week sophomore Family Medicine preceptorship, her strengths were identified as "...very reliable...extremely willing to learn and assist with patients...always available...a wonderful student and caring person..."

Monique opted to participate in the third year program of integrated clerkships in a longitudinal ambulatory setting, which is called the "Yankton Ambulatory Program". The philosophy of this program is to deliver an educational program that is ambulatory based, allows continuity of care, and is problem oriented and student centered. The entire twelve months of the required third year clinical program is centered in a multidisciplinary clinic. The clinic schedule is designed to place the student in a specialty practice (Family Medicine, General Internal Medicine, General Surgery, Obstetrics and Gynecology, Pediatrics and Adolescent Medicine, and Psychiatry) in the Yankton Medical Clinic or one of its affiliated teaching sites during repeating two week cycles. Consequently, the student is not "on" a given specialty for a set number of weeks, but is actually on all six specialties throughout the entire twelve months and completes a curriculum in those clerkships similar to the more traditional "block" structure on our other two campuses.

The student is introduced to patients in the clinic, and continues to follow the patient during any hospitalizations or clinic return visits throughout the year. This provides many opportunities for students to gain a continuity experience in patient care. The student has a specific responsibility to be the coordinator of the patient's health care and to assure provision for meeting the patient's health needs.

A Coordinating Committee of Faculty meets monthly to evaluate the progress of each student. The students are evaluated in five major areas of assessment that bridge across all of the disciplines: 1. Patient assessment skills including directed history and physical examination; 2. Patient management skills including diagnostic, educational and treatment plans; 3. Problem solving skills as determined by small group performance, evaluation by attending physicians, and Triple Jump evaluations; 4. Objective knowledge base as determined by NBME subject exams; 5. Interpersonal skills and physician-related characteristics. At the end of the year, the Coordinating Committee uses a scoring system for assigning the grades in each of the 5 areas. Besides these courses, the students also take a Clinical Colloquium course and a Radiology course along with their classmates from the other campuses.

The Yankton Ambulatory Program {YAP} scoring system is on a scale of 1-4 with individual statements for each of the five areas. In general the scale should be interpreted as: 4=Exceptional skill development, rarely achieved by a third year medical student; 3.5=Advanced development of most skills for third year medical student; 3=Demonstrated ability to use basic skills, performs at a level of an average third year medical student; 2.5=Some important skills not attained, performs at less than a third year medical student of comparable education level; 1=Most essential skills cannot be demonstrated, performs at significantly less than third year medical student. On this scale, a score of 3.8-4.0 = a grade of "A", 3.0-3.7 = "B", 2.0-2.9 = "C". With this standard, a grade of "A" is truly an outstanding achievement. All scores within this form of bracket {} represent the Yankton Ambulatory Program score, which is an indicator of how that student fell within the overall grade range for the Yankton Ambulatory Program. For example, a grade of 3.8 would approximate 90%, a grade of 3.9 approximates 95%, and a grade of 4.0 approximates 100%. This YAP score is different from the GPA as shown on the student's transcript since the GPA is based on the standard A=4, B=3, C=2, etc.

CLINICAL RECORD

The grades for the third year are included along with a Yankton Ambulatory Program score in {brackets} and sample narrative comments from evaluations for each of the five major areas in the curriculum.

Patient Assessment skills (H&P): Grade "A". YAP Score {3.8} "...very impressed with her interview skills, efficient and accurate...good communication with patients...very good, very detailed...H&P's focused and detailed...great job of eliciting problems...excellent content of H&P's..."

Patient Management skills (Dx & Treatment): Grade "A". YAP Score {3.8} "...very good differential...very thorough and systematic...elaborate treatment plans for their complete bio-psycho-social profile..."

Problem Solving skills: Grade "A". YAP Score {3.8} [Scored A-, A and B+, for her three Triple Jump exercises.] Comments from small group and attendings included "...excellent problem solving skills...sees the patient as a whole in identifying risks/problems...good presentation and participation...would pursue questions to a very detailed degree – showing extensive research...questions are insightful...she is thorough and pleasant...an impressive group member..."

Objective Knowledge: Grade "A". YAP Score {3.9} [Scores on the six NBME subject exams ranged from 78 (65th percentile) in Internal Medicine, included an 88 (97th percentile) in Family Medicine, with the highest score of 90 (98th percentile) in Ob/Gyn.]

Interpersonal Skills (physician related characteristics): Grade "A". YAP Score {3.9} "...hard worker, enthusiastic, punctual...patient's will appreciated Monique's bedside manner...wonderful personality, will make great clinician...outstanding interpersonal skills...very interested, motivated, reliable...excellent rapport with patients...received numerous positive comments from patients, nurses and support staff regarding Monique, and I agree...great interpersonal and communication skills..."

For her two weeks of optional fourth-year courses available in the third year, Monique took an elective in Ob/Gyn with an "A" and an evaluation that stated "...great student... responsible, knowledgeable..."

Although fourth year courses are not included in the grade summary, Monique has completed an extramural elective in Ob/Gyn in Haiti with a grade of "A" and an evaluation from the attending physician that stated "...excellent clinical/technical skills...worked hard and was willing to learn...exceptional fund of knowledge...draws on her knowledge from her days as a nurse and adds the updated medical knowledge to provide excellent care for difficult patients...exceptional professionalism...cared for patients, developed rapport with them..."

SUMMARY

In summary, Monique Yoder has demonstrated an outstanding fund of basic science and clinical knowledge and the ability to apply that knowledge in clinical situations. As one of the Basic Science faculty during her medical education, I have the opportunity to get to know every student in the academic environment as well as the non-academic. I am pleased that the clinical evaluations have both identified and confirmed her strengths as being a student who is fully committed to learning about her patients through her excellent procedures for gathering histories and performing the physical exam. She has an exceptional knowledge base along with great clinical experiences that allow her to use this knowledge in a very comprehensive manner to attend to the entire complex of an individual patient's needs. She is someone who always treats everyone with respect, and she knows the art of listening and focusing her attention on the individual, even when there are potential distractions. She is often commended for her

motivation, punctuality, and commitment to follow through on responsibilities. We are confident that Monique is well prepared to continue her educational program, and are pleased to strongly support her application for residency training.

Sincerely,

Paul C. Bunger, Ph.D.,
Dean, Medical Student Affairs
Paul.Bunger@usd.edu

Attachments:

In compliance with the AAMC Guidelines for Preparation of the MSPE, this letter also includes:

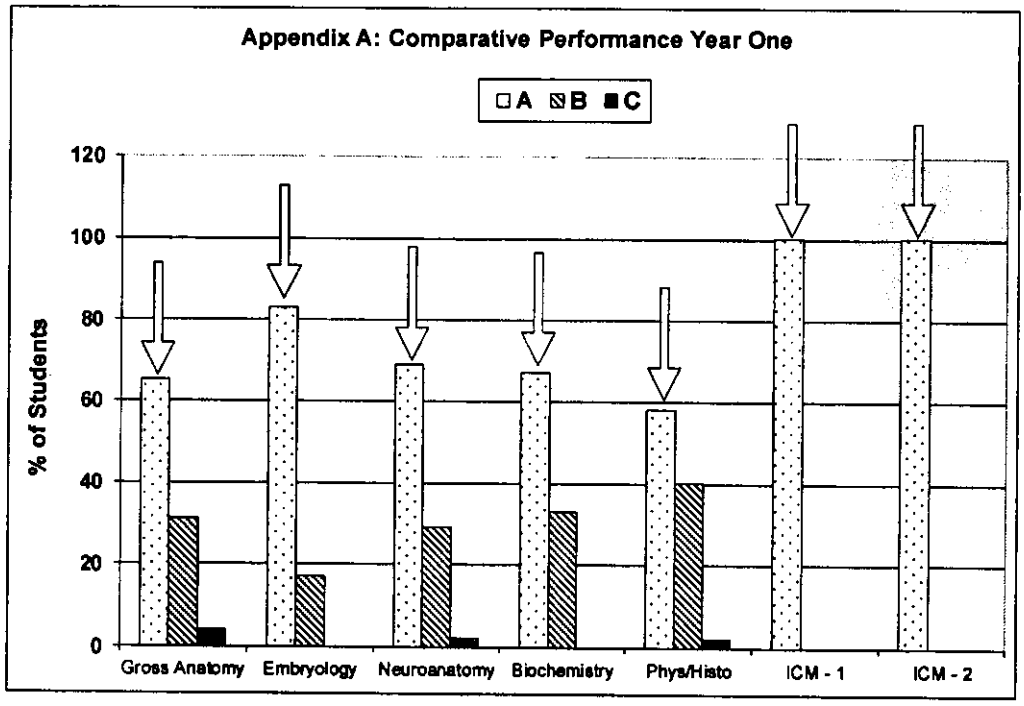
Appendix A – Graphic comparative representation for years one and two.

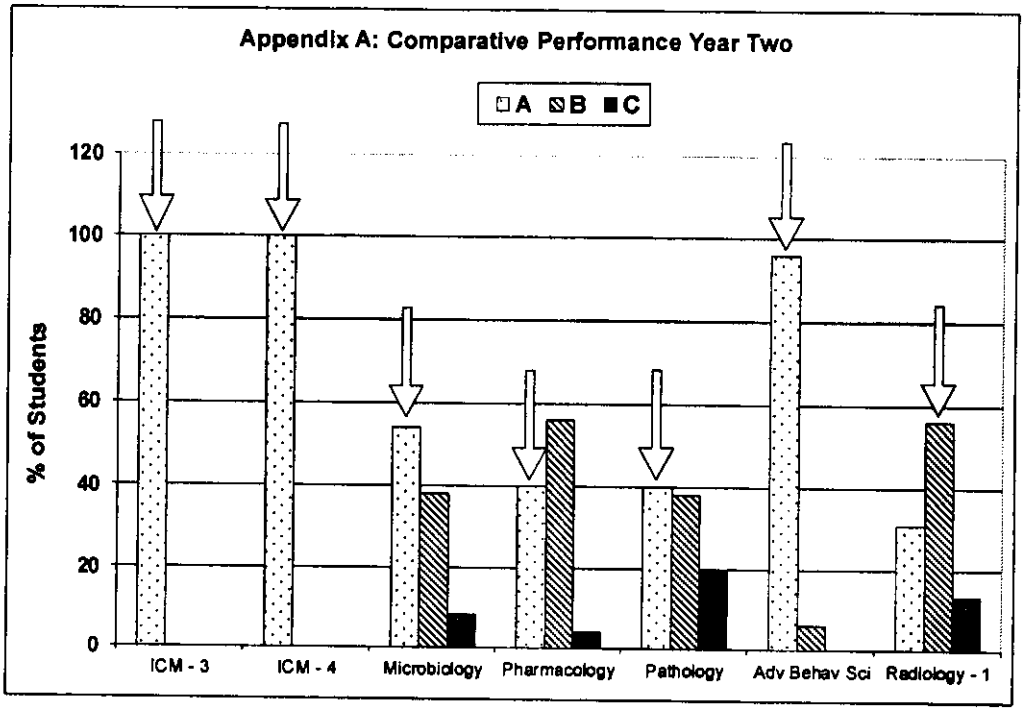
Appendix B – Graphic comparative representation for year three.

Appendix D – Graphic comparative representation of overall GPA by quartile.

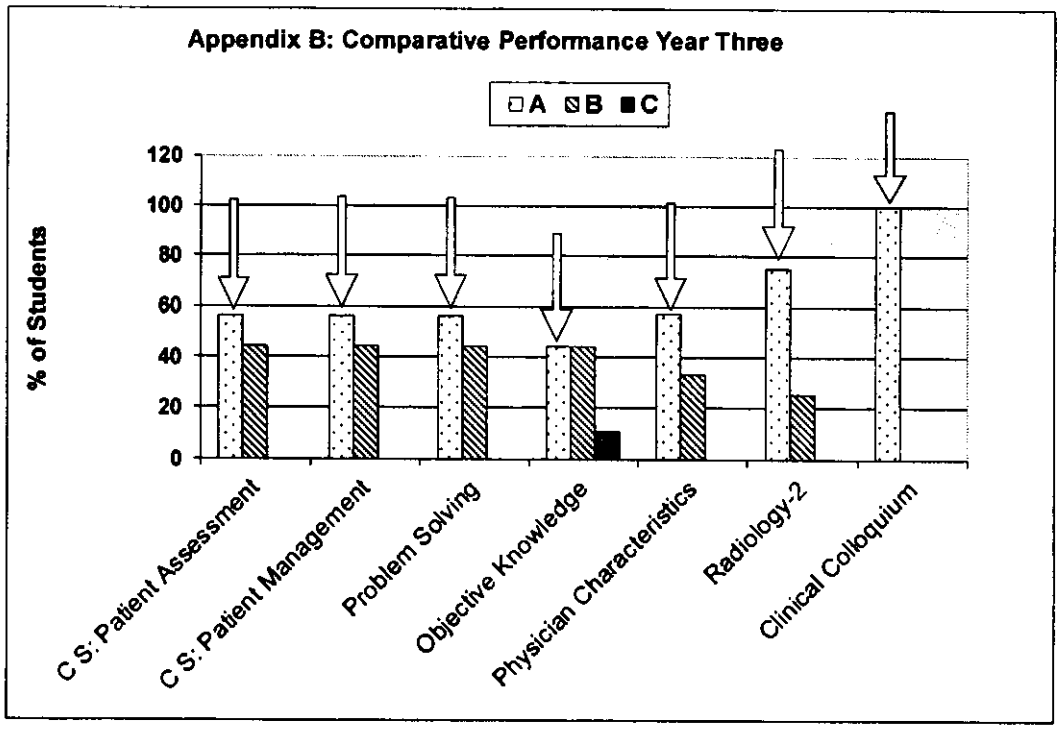
Appendix E – Medical school specific information.

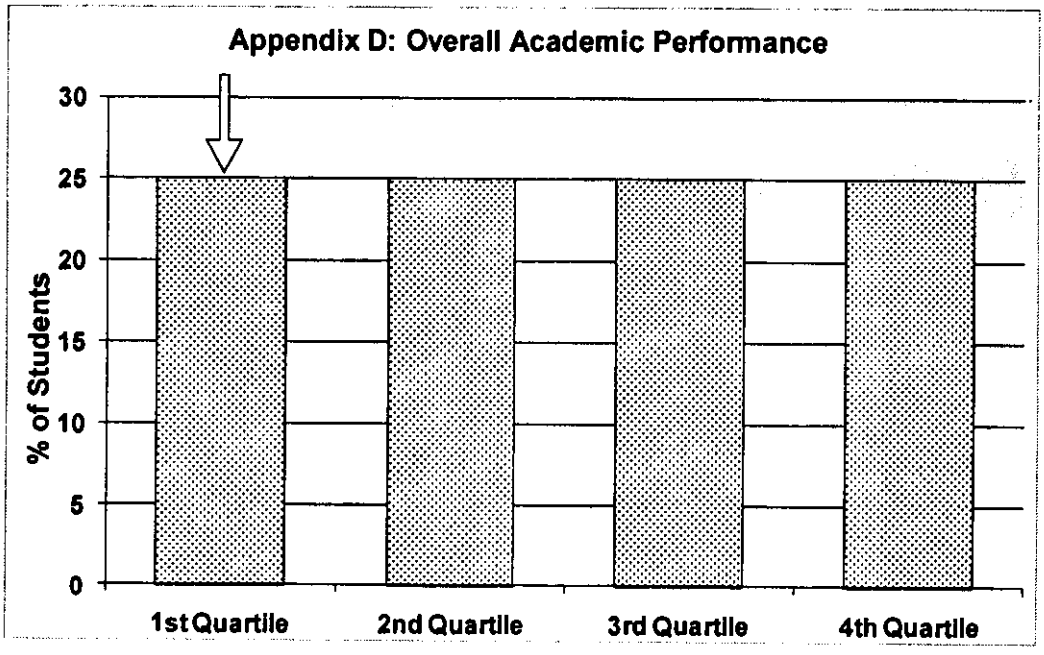
Monique Yoder





Monique Yoder





APPENDIX E – Sanford School of Medicine of The University of South Dakota
Class of 2012

The mission statement includes "...to receive a quality broad-based medical education with an emphasis on Family Medicine. The curriculum is to be established to encourage graduates to serve people living in medically underserved areas..." Although this emphasis encourages students to pursue Family Medicine and also alerts students to the needs of the underserved, graduates are broadly trained in the core areas of medicine and are well prepared to enter any specialty they choose and to practice in any setting.

There is a different approach, but the same educational objectives for each of the clinical campuses. Campus-specific features that apply to this student are included in the introductory portion of the *ACADEMIC PROGRESS* paragraph.

Students matriculate the first Monday of August, and the first year ends in mid May. The second year also begins the first Monday of August, and finishes with completion of a four week Family Medicine preceptorship in mid May. The third year begins in early July, and continues until the start of the fourth year the following July. Students must pass USMLE Step 1 to continue in the third year beyond November. Students must pass an OSCE administered by the medical school at the start of their fourth year, and are required to pass USMLE Step 2-CK and to take USMLE Step 2-CS in order to graduate. Students have 15 weeks of required clerkships in the fourth year, and 22 weeks of electives of which 2 may be taken late in the third year. Grades for these two weeks are considered part of the fourth year and are not included in the grade averages for year three. During their fourth year, most students attend a four-week elective as a visiting student at another medical school. Commencement is early May.

Grades are assigned on an A – B – C – D – F scale with D and F being unsatisfactory performance that results in either remediation or dismissal. In general, 91% and above = A, 81-90 = B and 71-80 = C. The second-year preceptorship is assigned four credits that are graded on a Pass/Fail system and does not figure into the GPA. The term "repetition" is used where a student is required to take additional time to repeat part of a course, or to repeat the entire course with the appearance of both grades on the transcript. This term is not used in cases where students are permitted to repeat an exam.

The MSPE narratives include selected quotes from attending physicians, clerkship directors or course directors which are filed as part of the grade evaluation and are enclosed within quote marks. The selection of quotes is designed to demonstrate a broad spectrum of information, to include primarily summative evaluations, and to emphasize the strengths of the student without omission of repetitive statements about weaknesses. Information within this form of square brackets [ ] represents editorial or clarifying information supplied by the author of the letter. Because not all graduating students may have taken a specific course the same year, all graphics for the appendices are based on a comparison between the members of the graduating class, at the completion of their 3rd year.

The MSPE is composed entirely by the Dean of Medical Student Affairs based on information in the academic file, an individual interview with the student, and knowledge gained about the student through frequent contacts during their educational career.

The student is permitted to review a draft of the MSPE prior to final submission for the dual purpose of assuring accuracy of demographic or personal information and to provide the student with the information that program directors will be reviewing.

USD Medical School Transcript

Yoder, Betty Monique
12306 Farinacci Ct
Cleveland OH 44106-2312

DEGREES WERE GRANTED FROM THE FOLLOWING REGENTAL UNIVERSITIES
The University of South Dakota
Doctor of Medicine, 05/04/12, Summa Cum Laude
Major: Medicine

SEND TO: **
FCVS
400 Fuller Wiser Road
Suite 300
Euless, TX 76039

Student Attended/Attending the Following Regental Universities:
The University of South Dakota, Vermillion, SD

Beginning Fall 2003, credit earned from all six SD Regental Universities will be identified and displayed under the term header

COURSE		Course Title	CRD	GRD	RPT
2008 FALL		**Institutional Credit - SD Board of Regents Universities**			
U ANAT	511	HUMAN GROSS ANATOMY	8.00	A	
U ANAT	512	HUMAN EMBRYOLOGY	2.00	A	
U BIOC	520	BIOLOGICAL CHEMISTRY	8.00	A	
U CLIN	511	INTRO CLINICAL MED I	2.00	A	
	TERM	ATT: 20.00 CMPL: 20.00 GPA:	4.000		
	CUM	ATT: 20.00 CMPL: 20.00 GPA:	4.000		
2009 SPRING		**Institutional Credit - SD Board of Regents Universities**			
U ANAT	531	MEDICAL NEUROSCIENCE	4.00	A	
U CLIN	512	INTRO CLINICAL MED II	3.00	A	
U PHGY	521	MEDICAL PHYSIOLOGY & HISTOLOGY	13.00	A	
	TERM	ATT: 20.00 CMPL: 20.00 GPA:	4.000		
	CUM	ATT: 40.00 CMPL: 40.00 GPA:	4.000		
2009 FALL		**Institutional Credit - SD Board of Regents Universities**			
U CLIN	621	INTRO CLINICAL MED III	5.00	A	
U CPHD	899D	DISSERTATION SUSTAINING	0.00	NG	
U MICR	620	MEDICAL MICROBIOLOGY	6.00	A	
U PATH	611	GENERAL & SPECIAL PATHOLOGY	13.00	A	
	TERM	ATT: 24.00 CMPL: 24.00 GPA:	4.000		
	CUM	ATT: 64.00 CMPL: 64.00 GPA:	4.000		
2010 SPRING		**Institutional Credit - SD Board of Regents Universities**			
U CLIN	622	INTRO CLINICAL MED IV	2.00	A	
U CLIN	698	ADVANCED BEHAVIORAL SCIENCE	3.00	A	
U FAMP	642	PRECEPTORSHIP	4.00	S	
U PHAR	620	MEDICAL PHARMACOLOGY	5.00	A	
U RADI	620	RADIOLOGY	1.00	B	
	TERM	ATT: 15.00 CMPL: 15.00 GPA:	3.909		
	CUM	ATT: 79.00 CMPL: 79.00 GPA:	3.987		
2010 FALL		**Institutional Credit - SD Board of Regents Universities**			
U CLIN	700	CLINICAL ASSESSMENT	9.00	A	
U CLIN	705	DIAGNOSTIC PATIENT MNGMT SKILL	9.00	A	
U CLIN	710	CLIN PROB SOLVING SKILLS	9.00	A	
U FAMP	805	CLINICAL COLLOQUIUM	2.00	A	
	TERM	ATT: 29.00 CMPL: 29.00 GPA:	4.000		
	CUM	ATT: 108.00 CMPL: 108.00 GPA:	3.990		
2011 SPRING		**Institutional Credit - SD Board of Regents Universities**			
U CLIN	715	OBJ MEDICAL KNOWLED	10.00	A	
U CLIN	720	PHYSICIAN-RELATED CHARAC	10.00	A	
U RADI	715	RADIOLOGY JR CLERKSHIP II	1.00	A	
	TERM	ATT: 21.00 CMPL: 21.00 GPA:	4.000		
	CUM	ATT: 129.00 CMPL: 129.00 GPA:	3.992		
2011 FALL		**Institutional Credit - SD Board of Regents Universities**			
U FAMP	823	EMERGENCY ROOM	3.00	A	
U MEDC	834	HEMATOLOGY & ONCOLOGY	2.00	A	
U MEDC	839	ACTING INTERNSHIP VA HOSP	4.00	A	
U OGYN	820	GYN & OBSTETRICS	2.00	A	
U OGYN	823	REPRODUCTIVE ENDOCRINOLOGY	2.00	A	
U OGYN	890	OB-GYN DESCHAPELLES HAITI	4.00	A	
U OGYN	890	OB/ GYN--(OGYN 827)	2.00	A	
U RADI	826	DIAGNOSTIC RADIOLOGY	1.00	A	
U SURG	764	ANES	2.00	A	
	TERM	ATT: 22.00 CMPL: 22.00 GPA:	4.000		
	CUM	ATT: 151.00 CMPL: 151.00 GPA:	3.993		
2012 SPRING		**Institutional Credit - SD Board of Regents Universities**			
U ANAT	811	CLINICAL ANAT ELECTIVE	2.00	A	
U FAMP	810	RURAL FAM MED CLERKSHIP	4.00	A	
U MEDC	823	DERMATOLOGY	2.00	A	
U MEDC	858	CLINCAL PHARMACOLOGY	2.00	A	
U PTRY	836	COMP INPATIENT PSYCHIATR	1.00	A	
U SURG	764	ORTHOPEDICS	2.00	A	
U SURG	820	GENERAL SURGERY	2.00	A	
	TERM	ATT: 15.00 CMPL: 15.00 GPA:	4.000		
	CUM	ATT: 166.00 CMPL: 166.00 GPA:	3.994		

	ATT HRS	CMPL HRS	GPA HRS	GRADE PTS	GPA
TRANSFER					0.000
INSTI USD	166.00	166.00	162.00	647.00	3.994
CUM	166.00	166.00	162.00	647.00	3.994

*** End of Transcript ***

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Jennifer Thompson
Registrar

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South Dakota State University, Brookings, SD 57007

SDSU Undergraduate Transcript

Yoder, Betty Monique
12306 Farinacci Ct
Cleveland OH 44106-2312

South Dakota State University
Bachelor of Science, 05/07/04, Cum Laude
Major: Nursing

SEND TO: **
FCVS
400 Fuller Wiser Road
Suite 300
Euless, TX 76039

1997 FALL Transfer Credit - Washington State University

COURSE		Course Title	CRD	GRD	RPT
CHEM	105	PRINCIPLES I	4.00	A	
CHEM	105A	PRINCIPLES I LAB	0.00	LR	
ENGL	198	COMP HONORS	3.00	A	
HIST	198	HIST HONORS	3.00	A	
MATH	107	ELEM FUNCTIONS	4.00	A	
NS	299	DIR STUDY	1.00	A	
NS	101	INTRO NS	2.00	A	
NS	100	DRILL / LAB	0.00	P	
	TERM ATT:	17.00 CMPL: 17.00 GPA:	4.000		
	CUM ATT:	17.00 CMPL: 17.00 GPA:	4.000		

1998 SPRING Transfer Credit - Washington State University

CHEM	106	PRINCIPLES II	4.00	A	
CHEM	106A	PRINCIPLES II LAB	0.00	LR	
ENGL	199	COMP LIT HONORS	3.00	A	
MATH	171	CALCULUS I	4.00	A	
NS	102	SHIPS SYST I	3.00	A	
NS	100	DRILL / LAB	0.00	P	
PEAC	108	BEG KARATE	1.00	P	
PSYC	198	PSYCH HONORS	3.00	A	
	TERM ATT:	18.00 CMPL: 18.00 GPA:	4.000		
	CUM ATT:	35.00 CMPL: 35.00 GPA:	4.000		

1998 FALL Transfer Credit - Washington State University

BIO	103	INTRO BIOL	4.00	B	
BIO	103A	INTRO BIOL LAB	0.00	LR	
CHEM	340	ORGANIC	3.00	B	
CHEM	341	ORGANIC CHEM LAB	2.00	A	
NS	201	SHIP SYST II	3.00	A	
SOC	198	SOC HONORS	3.00	A	
	TERM ATT:	15.00 CMPL: 15.00 GPA:	3.533		
	CUM ATT:	50.00 CMPL: 50.00 GPA:	3.857		

2000 FALL Institutional Credit - SDSU

BIO	311	PRINCIPLES OF ECOLOGY	3.00	A	
FREN	101	INTRODUCTORY FRENCH I	4.00	A	
PHYS	111	INTRODUCTION TO PHYSICS I	4.00	C	
PHYS	112	INTRODUCTN PHYSICS I LAB	0.00	LR	
GR	143	MASTER LIFETIME LRNG SKILLS	2.00	A	
ZOOL	221	ANATOMY	3.00	B	
ZOOL	222	ANATOMY LAB	0.00	LR	
	TERM ATT:	16.00 CMPL: 16.00 GPA:	3.313		
	CUM ATT:	66.00 CMPL: 66.00 GPA:	3.723		

2001 SPRING Institutional Credit - SDSU

BIO	153	GENERAL BIOLOGY II	4.00	A	
BIO	154	GENERAL BIOLOGY II LAB	0.00	LR	
CHEM	328	ORGANIC CHEMISTRY	4.00	B	
CHEM	329	ORGANIC CHEMISTRY LAB	0.00	LR	
PHYS	113	INTRODUCTION TO PHYSICS II	4.00	B	
PHYS	114	INTRODUCTN PHYSICS II LAB	0.00	LR	
	TERM ATT:	12.00 CMPL: 12.00 GPA:	3.333		
	CUM ATT:	78.00 CMPL: 78.00 GPA:	3.662		

2001 FALL Institutional Credit - SDSU

ZOOL	325	MAMMALIAN PHYSIOLOGY	4.00	B	
ZOOL	325A	MAMMALIAN PHYSIOLOGY LAB	0.00	LR	
HDFS	210	LIFESPAN DEVELOPMENT	3.00	A	
MICR	231	GENERAL MICROBIOLOGY	4.00	A	
MICR	232	GENERAL MICROBIOLOGY LAB	0.00	LR	
NFSH	321	HUMAN NUTRITION	3.00	A	
SPCM	101	FUNDAMENTALS OF SPEECH	3.00	A	
	TERM ATT:	17.00 CMPL: 17.00 GPA:	3.765		
	CUM ATT:	95.00 CMPL: 95.00 GPA:	3.681		

2002 SPRING Institutional Credit - SDSU

NURS	264	PROFESSIONAL PERSPECTIVES I	1.00	A	
NURS	265	HLTH ASSESSMENT&INTERVENTNS	4.00	A	
NURS	265A	HLTH ASSES&INTERVENT LAB	0.00	LR	
NURS	280	PROFESSIONAL COMMUNICATION	3.00	A	
NURS	280A	PROFESSIONAL COMMUN LAB	0.00	LR	
NURS	282	HEALTH PROMOTION	2.00	B	
NURS	323	INTRO TO PATHOPHYSIOLOGY	3.00	A	
	TERM ATT:	13.00 CMPL: 13.00 GPA:	3.846		
	CUM ATT:	108.00 CMPL: 108.00 GPA:	3.701		

2002 FALL Institutional Credit - SDSU

NURS	304	PROFESSIONAL PERSPECTIVS II	1.00	A	
NURS	320	FAMILY AS CLIENT:EMERG/DEVL	6.00	A	
NURS	320A	FAM CLIEN EMER:DEV CLIN LAB	0.00	LR	
NURS	330	FAMILY HLTH ENVIRN-LIFESPN	3.00	A	
NURS	330A	FAM HLTH ENV-LIFES CLIN LAB	0.00	LR	
PHA	321	PHARMACOLOGY	3.00	B	
	TERM ATT:	13.00 CMPL: 13.00 GPA:	3.769		
	CUM ATT:	121.00 CMPL: 121.00 GPA:	3.708		

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Joyce Kepford
Joyce Kepford
Registrar

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Yoder, Betty Monique(Continued from page 1)

COURSE		Course Title	CRD	GRD	RPT
2003 SPRING		**Institutional Credit - SDSU**			
HSC	443	PUBLIC HEALTH SCIENCE	3.00	B	
NURS	364	PROFESSIONAL PERSPECTV III	1.00	A	
NURS	370	ACUTE HEALTH CARE I	5.00	B	
NURS	370L	ACUTE HLTH CARE I CLIN LAB	0.00	LR	
NURS	375	CHRONIC HEALTH CARE I	5.00	A	
NURS	375L	CHRON HLTH CARE I CLIN LAB	0.00	LR	
	TERM	ATT: 14.00 CMPL: 14.00 GPA:	3.429		
	CUM	ATT: 135.00 CMPL: 135.00 GPA:	3.679		

Beginning Fall 2003, credit earned from all six SD Regental Universities will be identified and displayed under the term header

2003 FALL		**Institutional Credit - SD Board of Regents Universities**			
S NURS	404	PROFESSIONAL PERSPECTVS IV	1.00	A	
S NURS	410	ADVNRSCARECLNTMED-SURHLTHPROB	6.00	A	
S NURS	410L	ADVNRSCARCLNTMED-SURHTHPRBLAB	0.00	LR	
S NURS	420	NURSCARECLIENTMENTLHLTHPRBLMS	4.00	A	
S NURS	420L	NRSCARECLNTMNTLHLTHPRBLMSLAB	0.00	LR	
S WMST	248	WOMEN IN LITERATURE	3.00	A	
	TERM	ATT: 14.00 CMPL: 14.00 GPA:	4.000		
	CUM	ATT: 149.00 CMPL: 149.00 GPA:	3.709		
2004 SPRING		**Institutional Credit - SD Board of Regents Universities**			
S NURS	464	PROFESSIONAL PERSPECTIVES V	2.00	A	
S NURS	475	COMMUNITY AS CLIENT	3.00	A	
S NURS	475L	COMM CLIENT CLN LAB	0.00	LR	
S NURS	495	PRACTICUM	6.00	A	
S NURS	495L	DIR ST NURSING CLIN LAB	0.00	LR	
S STAT	281	INTRO TO STATISTICS	3.00	A	
	TERM	ATT: 14.00 CMPL: 14.00 GPA:	4.000		
	CUM	ATT: 163.00 CMPL: 163.00 GPA:	3.735		

	ATT HRS	CMPL HRS	GPA HRS	GRADE PTS	GPA
TRANSFER	50.00	50.00	49.00	189.00	3.857
INSTI SDSU	113.00	113.00	113.00	416.00	3.681
CUM	163.00	163.00	162.00	605.00	3.735

*** End of Transcript ***

Joyce Kepford
Joyce Kepford
Registrar

SEAL VERIFIED

TO VERIFY: TRANSLUCENT GLOBE ICONS MUST BE VISIBLE WHEN HELD TOWARD A LIGHT SOURCE

RAISED SEAL NOT REQUIRED

- This official university transcript is printed on security paper.
- A security statement containing the names of the six public universities will appear when photocopied.
- A black and white document is not official.

PURSUANT TO THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974, INFORMATION CONTAINED HEREIN SHALL NOT BE RELEASED TO A THIRD PARTY WITHOUT THE WRITTEN AUTHORIZATION OF THE STUDENT.

SEAL VERIFIED
359727

TRANSCRIPT GUIDE AND AUTHENTICITY STATEMENT APPEAR ON REVERSE SIDE

TRANSCRIPT GUIDE

BEGINNING FALL SEMESTER 2003

(Additional historic information for each university is enclosed as needed)

Black Hills State University, Spearfish, SD 57799 (605) 642-6092
Dakota State University, Madison, SD 57042 (605) 256-5154
Northern State University, Aberdeen, SD 57401 (605) 626-2012
South Dakota School of Mines and Technology, Rapid City, SD 57701 (605) 394-2400
South Dakota State University, Brookings, SD 57007 (605) 688-6195
The University of South Dakota, Vermillion, SD 57069 (605) 677-5301

Accreditation: All of the above universities are fully accredited by The Higher Learning Commission of the North Central Association of Colleges and Schools. Each university is separately accredited.

Explanation of Transcript

October 2003, the individual student information system databases of the six South Dakota public universities were merged into one database. Beginning Fall Semester 2003, all credit earned at any of the six universities will be listed under the term header. An identifier for the university teaching each course is placed on the transcript prior to the Course Subject as follows:

- B – Black Hills State University
- D – Dakota State University
- M – South Dakota School of Mines and Technology
- N – Northern State University
- S – South Dakota State University
- U – The University of South Dakota

This conversion to a single database necessitates that the student enrolled Before the Merge, or Before and After the Merge, will receive a transcript from each university attended at each level (credit has been transferred between the universities). Students who attend After the Merge Only will receive one combined transcript. Some students who attended prior to 1987 will receive a transcript that is a copy of their hard copy (non-electronic) transcript.

Transcripts are issued only upon the written request of the student and payment of the required fees. In compliance with the Family Educational Rights and Privacy Act of 1974, no information contained on a transcript is to be released to a third party without the written consent of the student.

Official transcripts issued will include all credit, at all levels, that has been earned at all six universities. Official transcripts are issued on security paper.

Academic Calendar

The universities are on a semester calendar: fall, spring, summer.

Academic Level

Undergraduate – at all six universities
Graduate – at all six universities
Medical School and Law School – only at The University of South Dakota

Academic Standing

A student is academically eligible to enroll unless indicated by an academic "Suspended" status.

Course Numbering

001-099 Pre-College, non degree credit
100-199 Freshman level
200-299 Sophomore level
300-399 Junior level
400-499 Senior level
500-599 Entry level graduate, open to approved seniors
600-699 Graduate level – open to approved seniors
700-799 Graduate level only
800-899 Doctoral and post-doctoral level
Law School – 700-899
Medical School – 400-499 (First and second year courses in Medicine); 500 and above (Courses in Medicine beyond the second year).

Repeated Courses

For the Undergraduate and Graduate academic levels, only the last grade is used in computing the grade point average. For the Law School, only the first grade is used in computing the grade point average. For the Medical School, all grades are averaged in the grade point average. Repeated courses are marked with an "R" or "Repeated."

Transferred Credit

All courses from regionally accredited post secondary undergraduate institutions are recorded as transferred and are expressed in semester hours. Other transfer credit is recorded as transferred only if it is equivalent to a specific course at one of the public universities. Official transcripts from other institutions are not reissued or copied for distribution.

Grading System

Undergraduate, Graduate, and Medical School Levels

Grades that calculate into the GPA

A	–	4 grade points per semester hour
B	–	3 grade points per semester hour
C	–	2 grade points per semester hour
D	–	1 grade point per semester hour
F	–	0 grade points per semester hour
WFL	–	0 grade points per semester hour

Grades that do not calculate into the GPA

AU	–	Audit
EX	–	Credit by Exam
Grade*	–	Academic Amnesty
CR	–	Credit
I	–	Incomplete
IP	–	In Progress
LR	–	Lab Grade Linked to Recitation Grade
NG	–	No Grade (0 CR Tracking/Sustaining Course)
NP	–	Normal Progress (Graduate only)
NR	–	Grade Not Reported by Instructor
RI	–	Incomplete - Remedial
RS	–	Satisfactory - Remedial
RU	–	Unsatisfactory - Remedial
S	–	Satisfactory
SP	–	Satisfactory Progress (Remedial Only)
TR	–	Note for NSE/MEDT
U	–	Unsatisfactory
W	–	Withdrawal
WD	–	Withdrawal (First 6 Courses)
WW	–	Withdrawal (All Courses)

Medical School

(Unique Grades Used – do not calculate into the GPA)

INC	–	Incomplete
IWD	–	Instructor Initiated Withdrawal
N	–	Pass-No Letter Grade
NC	–	No Credit
NCI	–	Incomplete Not Finished

Law School

Numeric grades are used.

Grades that do not calculate into the GPA

N	–	Pass-No Numeric Grade

TO TEST FOR AUTHENTICITY: Translucent globe icons *MUST* be visible from both sides when held toward a light source. The face of this transcript is printed on blue SCRIP-SAFE® paper with the names of the institutions appearing in white type over the face of the entire document.

BLACK HILLS STATE UNIVERSITY • DAKOTA STATE UNIVERSITY • NORTHERN STATE UNIVERSITY • SOUTH DAKOTA SCHOOL OF MINES AND TECHNOLOGY • SOUTH DAKOTA STATE UNIVERSITY • THE UNIVERSITY OF SOUTH DAKOTA

ADDITIONAL TEST: The institutional names and the word COPY appear on alternate rows as a latent image. When this paper is touched by fresh liquid bleach, an authentic document will stain brown. A black and white or color copy of this document is not an original and should not be accepted as an official institutional document. This document cannot be released to a third party without the written consent of the student. This is in accordance with the Family Educational Rights and Privacy Act of 1974. If you have questions about this document, please contact one of the offices above. ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE!

SEAL VERIFIED

152350-2351-235215

SCRIP-SAFE® Security Products, Inc. Cincinnati, OH

I, [signature], Registrar Officer at Sanford School of Medicine at The University of South Dakota, do herby affirm that this is a copy of an original diploma issued by The University of South Dakota. Affirmed this 16th day of March 2016.

The University of South Dakota

On the recommendation of the Faculty and the

Sanford School of Medicine

and under the authority of The Board of Regents
The University of South Dakota has conferred the degree of

Doctor of Medicine

Summa Cum Laude

upon

Monique Yoder

with all the rights and privileges appertaining to that degree.
Awarded at Vermillion, South Dakota,
this 4th day of May, 2012.

[signature]
President, Board of Regents

[signature]
President of the University

[signature]
Dean

[signature]
Registrar

ELECTRONIC SEAL VERIFIED

Diploma MS

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: Cleveland Clinic **Affiliated University:**

Address Line 1: 9500 Euclid Avenue, A81

Address Line 2:

Country: US **City:** Cleveland **State/Prov.:** OH **Zip Code:** 44195

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

Verification For: Katsuki, Monique Yoder **Date of Birth:** September 02, 1979

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	Training Level	From	To	Successfully Completed?	Accredited by	Specialty/Subspecialty
I	1	07/01/2012	06/30/2013	Yes	ACGME	Obstetrics and Gynecology
R	2	07/01/2013	06/30/2014	Yes	ACGME	Obstetrics and Gynecology
R	3	07/01/2014	06/30/2015	Yes	ACGME	Obstetrics and Gynecology

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: EliasTraboulsi **MD/DO:** Yes

Signature: *Elias Traboulsi*

Title: Director, Graduate Medical Education **Date:** 03/14/2016

Tel: (216) 444-5690 **Fax:** **Email:** delonge@ccf.org

ELECTRONIC SEAL VERIFIED 359727

119119 215818592

Verification of Graduate Medical Education

Program Participation (Continued):

Program Type	Training Level: 4	Specialty/Subspecialty: Obstetrics and Gynecology	
R	From: 07/01/2015	To: 06/30/2016	
	Successfully Completed?	In Progress	
	Accredited by: ACGME		

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	Training Level:	Specialty/Subspecialty:	
	From:	To:	
	Successfully Completed?		If no, was credit awarded?
	Accredited by:		

Program Type	Training Level:	Specialty/Subspecialty:	
	From:	To:	
	Successfully Completed?		If no, was credit awarded?
	Accredited by:		

Program Type	Training Level:	Specialty/Subspecialty:	
	From:	To:	
	Successfully Completed?		If no, was credit awarded?
	Accredited by:		

Program Type	Training Level:	Specialty/Subspecialty:	
	From:	To:	
	Successfully Completed?		If no, was credit awarded?
	Accredited by:		

Rotation Schedule

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: Monique Yoder Katsuki

Cleveland Clinic

Obstetrics and Gynecology

Unusual Circumstances

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

End of report for: Monique Yoder Katsuki

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

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: 04/01/2016

Federation Credentials Verification Service

ATTN: FCVS

FCVSID: 359727

Examinee: Yoder, Betty Monique **Examinee ID:** 52352838

Alt Name(s): **Date of Birth:** 09/02/1979

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
6/22/2010	Pass	242	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
9/16/2011	Pass	243	(189)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
12/19/2011	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
6/3/2013	Pass	228	(190)	

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

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

Examinee: Yoder, Betty Monique

Examinee ID: 52352838

Date of Birth: 09/02/1979

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.

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.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, 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 Physician Data Center 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.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

Submission Date and Time: 8/21/2018 7:15 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Title
Dr.
First Name
Monique
Middle Name
Yoder
Last Name
Katsuki
Maiden Name
Betty Monique Yoder
Social Security Number
REDACTE
Date of Birth
9/2/1979
Email Address
yodermonique@gmail.com
Phone Number
6056702746
Other Phone Number
No Response

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
Yoder Betty Monique; Katsuki Betty Yoder
What is your gender?
Female
What is your ethnicity?
White
In which country were you born?
United States
In which state were you born (if United States)?
Ohio
In which city were you born?

Wooster

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

6437 Westminster Drive
Parma
OH
44129
null

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

6437 Westminster Drive
Parma
OH
44129
null

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
Has your spouse served in the military?
Yes
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:
katsukm@ccf.org

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue.

Question - At any time since signing your last application for renewal of your certificate have you ever been denied a license to prescribe, dispense, administer, supply, or sell a controlled substance by the drug enforcement administration or appropriate issuing body of any state or jurisdiction, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever had a restriction of a license issued by the drug enforcement administration or a state licensing administration in any jurisdiction, under which you could prescribe, dispense, administer, supply or sell a controlled substance, that was restricted, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying, or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever been subject to disciplinary action by any licensing entity that was based, in whole or in part, on inappropriate prescribing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - Have you completed at least two hours of continuing medical education, annually for the past two years, that were certified by the Ohio State Medical Association or the Ohio Osteopathic Association, that assist physicians in diagnosing qualifying medical conditions and treating these conditions with medical marijuana including the characteristics of medical marijuana and possible drug interaction.
Answer -
Question - At any time since signing your last application for renewal of your certificate do you have an ownership or investment interest in or compensation agreement with any medical marijuana entity or applicant?
Answer -
Question - 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?
Answer - No

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - 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; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
Answer - No

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - Yes

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

Question - Primary NPI Number
Answer - 1366708950

Question - Primary DEA Number
Answer - FK6076788

Question - What is your current employment status?
Answer - Actively working in a position that requires the license I am renewing

Question - Do you currently possess an active license other than that for which you are renewing?

Answer - No

Question - On average, how many hours per week do you work under the license for which you are currently applying or renewing?
Answer - 60

Question - How many locations are you currently working in that require the license you are renewing?
Answer - 3

Question - Please provide the following information for up to 3 locations in which you use the license you are renewing, beginning with the locations you spend the most time: Facility Name, Address, City, State, Zip Code, Health Care Facility Type
Answer - Willoughby Hills Family Health Center, 2570 Som Center Rd, Willoughby Hills, OH 44094 Hillcrest Hospital, 6780 Mayfield Rd, Mayfield Heights, OH 44124 Preterm, 12000 Shaker Blvd, Cleveland, OH, 44120

Question - Do you have hospital privileges?
Answer - Yes

Question - Which of the following best describes your five-year employment plan?
Answer - Maintain practice hours as is

Question - Please select a language, other than English that you personally use to communicate with patients. Do not include a language that you use with the help of an interpreter or language software.
Answer - Not Applicable

Question - What is your U.S. residency status related to your employment?
Answer - U.S. Citizen

Question - Do you consider yourself Hispanic, Latino/a or of Spanish origin?
Answer - No

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation
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.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 8/21/2018 7:15 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
Monique Katsuki
Submit your Application -After clicking the ‘Submit’ button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.