112085

State Medical Board of Ohio

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

APPLICATION FOR TRAINING CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

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

PERSONAL INFORMATION

Check only one: ☒ **MD** ☐ **DO**

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

U.S. Social Security Number: Redacted

Full Name (Use no initials):	Last (Surname)	First	Middle	Suffix (Jr., II)
	Yoder	Betty	Monique	

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

Physicians Address (Be sure to notify the Board of any change in address):	Number & Street			
	1218 1/2 Walnut			
	City	State	Zip Code	Country
	Yankton	SD	57078	USA

TRAINING PROGRAM INFORMATION

Ohio Training Program Address (Hospital in Ohio where you will be starting your training):	Hospital & Department		
	The Cleveland Clinic Foundation, Graduate Medical Education - NA23		
	Number & Street		
	9500 Euclid Avenue		
	City	State	Zip Code
	Cleveland	OH	44195

Dates of Training: Beginning Date: Mo/Day/Yr 7/1/2012 Ending Date: Mo/Day/Yr 6/30/2013

J-1 and H-1B VISA

To be completed by International medical school graduates only:

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

If YES check which one? ☐ J-1 ☐ H-1B

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MEDICAL OR OSTEOPATHIC EDUCATION

Medical or Osteopathic School of Graduation:

School Name: Sanford School of Medicine University of South Dakota
City: Vermillion | State: SD | Country: USA

Dates Attended: From: Mo/Yr 7 /2008 To: Mo/Yr 5 /2012

Degree Received: MD Date Received: Mo/Day/Yr 5 / 5 /2012

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

School Name: NONE
City: | State: | Country:

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

Reason degree not received at this school:

FIFTH PATHWAY PROGRAM

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

Hospital or Institution: NONE
Name of Medical School:
City: | State: | Country:

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

ECFMG CERTIFICATE

To be completed by International medical school graduates only:

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

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

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Applicant Name: Betty Monique Yoder Date: 4/18/12

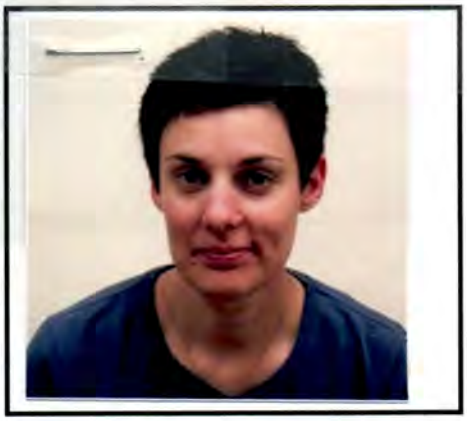
PHYSICAL DESCRIPTION

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

Birth Date: Mo/Day/Yr 09/02/1979

Birth Place: City: Wooster | State: OH | Country: USA

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



PHYSICAL DESCRIPTION

Height 5'5"

Weight 145 pounds

Hair Color brown

Eye Color brown

Identifying Marks None

Date Photo Taken: 3/2012
mo/yr

LICENSES IN THE UNITED STATES & CANADA

List ALL states/provinces, whether the license is current or not, in which you are or have been licensed, including temporary, educational permits, limited licenses, etc., to practice medicine and surgery or osteopathic medicine and surgery. Indicate license number, date of issuance and the type of license. If additional space is needed, attach an extra sheet. **(If none, enter "NONE") A Form 2, Verification of License form must be sent to each state listed.**

STATE/PROVINCE	ISSUE DATE	LICENSE #	TYPE OF LICENSE	LICENSE CURRENT
	MO/YR		*✓ ONLY ONE*	*✓ ONLY ONE*
NONE			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:

Applicant Name: Betty Monique Yoder Date: 4/18/12

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES

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

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

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

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

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

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

From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical MEDICAL BOARD APR 30 2012 %Admin.

Applicant Name: Betty Monique Yoder Date: 4/18/12

From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department	%Clinical %Admin.
From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City State/Country Zip Code	Position & Department MEDICAL BOARD APR 30 2012	%Clinical %Admin.

Applicant Name: Betty Monique Yoder Date: 4/18/12

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
ADDITIONAL INFORMATION

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

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

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

Applicant Name: Betty Monique Yoder Date: 4/18/12

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

Applicant Name: Betty Monique Yoder Date: 4/18/12

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

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

* *

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

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

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

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

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

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

		YES	NO
	b) Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	☐	☒

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Applicant Name: Betty Monique Yoder Date: 4/18/12

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

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

* *

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

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

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

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

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Applicant Name: Betty Monique Yoder Date: 4/18/12

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
MALPRACTICE CLAIM INFORMATION

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

Name of Physician (print clearly): N/A

MALPRACTICE COMPLAINT:

Name of Patient: _____

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

Date of Incident: _____ Date Suit Filed: _____

Location of incident: _____
Hospital, institution or other

_____
Address

_____
City State Zip Code County

Name and Address of Involved Insurance Carrier: _____

_____

FILED AGAINST: ❑ Individual Physician ❑ Group ❑ Hospital

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

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

_____

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

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

Name of Court: _____

Date of Settlement: _____ Docket #: _____

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

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

_____

_____

_____

_____

_____

_____

_____

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Betty Monique Yoder
Physician's Signature

4/18/12
Date

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

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

ss STATE OF: Ohio

COUNTY OF: Cuyahoga

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

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

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

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

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

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

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

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

Betty Monique Yoder
Signature of Applicant

Subscribed and sworn to before me this 17th day of April 20 12.

Thanks A. Ann
Signature of Notary Public

(NOTARY SEAL)

03-07-2016
Date Commission Expires

MEDICAL BOARD
APR 30 2012

THIS FORM CANNOT BE FAXED

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

STIPULATION AND AGREEMENT

This Stipulation and Agreement is made and entered on this ___ day of _____, 2008, by and between Jay Munsch, the above-named Plaintiff, and Betty Munsch, the above-named Defendant.

WHEREAS, the parties hereto were married on May 10, 2005 at Vermillion, South Dakota, and ever since have been and now are husband and wife, and

WHEREAS, by reason of circumstances and conditions between the parties, they are now separated and living apart, and the above-entitled action for dissolution of the marriage is now pending in Circuit Court, First Judicial Circuit, County of Turner; and

WHEREAS, Plaintiff and Defendant contend that it is the purpose of this Stipulation and Agreement to make a complete and final settlement of all rights and claims that each may have against the other, to provide fairly and adequately for their support and maintenance, to memorialize the separation of the parties and their Agreement, to finalize the division of property owned by them or either of them, and all other rights of property otherwise growing out of the marriage relationship that either of them now has or may hereafter have or claim to have in any property of every kind, nature, and description, real or personal, now owned or which may hereafter be acquired by either of them, and acknowledgement by the parties that this Agreement is subject to the approval of the Court, and that if the Court finds grounds for and makes a decree of divorce for either party the

conditions of this Agreement, or any part thereof, may be incorporated in the Judgment and Decree of Divorce, as the Court shall deem necessary; and

NOW, THEREFORE, in consideration of the promises herein contained, and mutual benefits to be derived therefrom, it is hereby stipulated and agreed by and between the parties hereto, subject to the approval of this Court as follows:

1. PURPOSE

The sole purpose of this Stipulation and Agreement is to adjust and settle the issues of division of property, assumption of financial obligations, and alimony and nothing herein shall be construed as an agreement that a divorce will be obtained, or that either party is assisting the other in obtaining a divorce. The terms of this Agreement may be incorporated by reference in any Judgment and Decree of Divorce that may be entered.

2. VEHICLES

That the Plaintiff shall have all right, title and interest in all vehicles now in his possession, free and clear of any claim by the Defendant. That the Plaintiff shall take said vehicles subject to the indebtedness thereon and shall save and hold harmless the Defendant therefrom. Further, the Plaintiff agrees to title the vehicles in his name only within sixty days of the execution of this agreement

That the Defendant shall have all right, title and interest in all vehicles in her possession, free and clear of any claim by the Plaintiff. That the Defendant agrees to take said vehicles subject to the indebtedness thereon and agrees to save and hold harmless the Plaintiff therefrom. Further, that the Defendant agrees to title the vehicles in her name within sixty days of the execution of this agreement.

3. PERSONAL PROPERTY

A. That the Plaintiff shall retain as his sole and separate property all of his personal clothing and effects, all household goods, appliances and such other items of personal property as are currently in his possession.

B. That the Defendant shall retain as her sole and separate property all of her personal clothing and effects, all household goods and such other items of personal property that are remaining in her possession.

C. That any encumbrance(s) relating to, accompanying or attached to an item of personal property shall be the sole responsibility of the party retaining such property and that party shall save and hold harmless the other therefrom.

4. RETIREMENT BENEFITS

That the parties agree that the Defendant and the Plaintiff shall retain any retirement account in their name free from any claim of the other party.

The parties further agree to execute any and all documents pertinent and necessary to affect the intent of the above-stated paragraph on or before the date of the filing of the Judgment and Decree of Divorce.

5. CHECKING AND SAVINGS ACCOUNTS

That Plaintiff and Defendant shall each retain the sums in their individual checking and savings accounts or business accounts for the exclusive ownership, use and possession of each.

6. LIFE INSURANCE

That the Plaintiff and Defendant may each maintain any life insurance policy or policies for which he or she is the insured, as his or her sole and separate property, and shall be free to rename the beneficiary of his or her own choosing.

7. DEBTS

The parties hereby agree that each party shall pay his or her own debts which appear in his or her own respective names which were incurred prior to or during the marriage or incurred from and after the date of the entry of the Judgment and Decree of Divorce.

Each of the parties agrees not to contract any debts, charges or liability for which the other of them or his or her property or estate shall or may become liable or answerable. Neither party shall charge or cause or permit to be charged to or against the other, nor secure or attempt to secure

any credit upon or in connection with the other or in his or her name alone. Each party shall promptly pay all debts and discharge all financial obligations which he or she may incur for himself or herself and does hereby agree to indemnify the other against any and all debts and other obligations which he or she may incur.

8. ALIMONY

That each party waives any claim or right to alimony past, present, or future.

9. ATTORNEY'S FEES

That each party agrees to pay his or her own attorney fees, tax, costs and necessary disbursements of this action.

If either Plaintiff or Defendant fail to live up to the terms of this stipulation and agreement, the party forced to enforce this stipulation and agreement through any type of legal process will be entitled to recover all their legal fees, expenses and costs incurred seeking to enforce this stipulation and agreement from the party who defaulted and failed to live up to the terms of this stipulation and agreement.

10. TAX CONSEQUENCES

The parties acknowledge that they have been separately advised by their respective attorneys that there may be certain tax consequences pertaining to this Agreement, that neither attorney has furnished tax advice with respect to this Agreement, that each party has been directed and advised to obtain independent tax advice from qualified tax accountants or tax counsel prior to signing this Agreement and that they have had the opportunity to do so.

11. WAIVER OF ESTATES

Except as otherwise set forth in this Agreement, Plaintiff and Defendant hereby mutually release and waive any and all right, title and interest accruing by operation of law or under any statute now or hereafter in force, or otherwise, to participate in the separate estates and property of each other, whether such property be real or personal or wheresoever located, and whether acquired before or subsequent to their marriage, and whether acquired before or subsequent to the date hereof, including any right of election to take against any Last Will and Testament of each other,

and any right to the administration of the estate of each other, except only as provided by Will or Codicil executed after the date of this Agreement.

12. EXECUTION OF DOCUMENTS

Each of the parties agrees to execute or have properly executed in legal form any documents of title, certificates or other instruments necessary to affect any of the provisions of this Agreement.

13. CONFLICT OF LAWS

This Stipulation and Agreement shall be construed in accordance with the substantive laws of the State of South Dakota.

14. WAIVER OF NOTICE

The parties hereto agree that Findings of Fact and Conclusions of Law may be waived, and the Defendant hereby waives notice of any trial or hearing brought on the claims set forth in Plaintiff's Complaint.

15. GROUNDS FOR DISSOLUTION

The parties hereto agree to consent that the above-entitled Court may find that there exist irreconcilable differences causing the irremedial breakdown of the marriage as the grounds for granting the anticipated Judgment and Decree of Divorce herein.

16. PROPERTY INTENTIONALLY OR INADVERTENTLY LEFT OUT

It is understood and agreed by and between the parties that this Agreement applies to all of the property known to the parties at this time, and that any property or property rights not contemplated or known at the time of this Agreement that have been deliberately withheld from the knowledge of the other, and/or not accounted for at the time of this Agreement, shall be considered to be the common property of the parties hereto, and shall be divided equally between the parties, but any and all property or property rights acquired subsequent to the day of this Agreement shall be the separate property of the party acquiring the same and neither party shall have any right or claim in and to said subsequently acquired property.

17. INTERFERENCE

The parties shall hereafter live separate and apart. Each party shall be free from interference, authority or control, direct or indirect, of the other party. Each party may, for his or her separate benefit, engage in any employment, business, or profession he or she may select. The parties shall not molest or interfere with each other in any aspect of their personal or professional lives.

18. RESORATION OF FORMER SURNAME

The parties agree that the Defendant shall have restored to her her former surname of Yoder.

19. REPRESENTATION OF THE PARTIES

Both parties have been advised of their discovery rights and the foregoing terms of this Agreement are based upon the representations of the parties to each other and their respective attorneys that they have made a thorough and complete disclosure of their assets, liabilities and overall financial positions, and each acknowledges that this Agreement is being executed in reliance on the validity of said information.

Both parties have read the foregoing Stipulation and Agreement and have signed the same with full knowledge of its contents and each acknowledges receipt of a copy of said Agreement.

20. FAIRNESS OF THE AGREEMENT

This Agreement is deemed to be fair by both parties and not the result of any fraud, duress or undue influence exercised by either party upon the other or by any person or persons upon either.

21. PARTIAL INVALIDITY

If any of the provisions of this Agreement are held to be invalid or unenforceable, all other provisions of this Agreement shall nevertheless continue in full force and effect.

22. MODIFICATION AND WAIVER

A modification or waiver of any provisions of this Agreement shall be effective only if made in writing and executed with the same formality as this Agreement. The failure of either party

to insist upon strict performance of any of the provisions of this Agreement shall not be construed as waiver of any subsequent default of the same or similar nature.

23. ENTIRE AGREEMENT

Plaintiff and Defendant agree that this Stipulation and Agreement constitutes the entire agreement of the parties and is a full and complete property settlement between the parties and no other or further agreement, oral or otherwise, constitutes part of the settlement.

Dated this 17th day of April, 2008.

JAY D. MUNSCH

STATE OF SOUTH DAKOTA)
:SS
COUNTY OF Yankton)

On this the 17th day of April, 2008, before the undersigned officer, personally appeared Jay D. Munsch, known to me or satisfactorily proven to be the person whose name is subscribed to the within instrument and acknowledged that he executed the same for the purposes therein contained.

IN WITNESS WHEREOF I hereunto set my hand and official seal the day and year first above written.

(SEAL)

Notary Public – South Dakota
My Commission Expires: 2-19-11

Dated this 15th day of April, 2008.

BETTY M. MUNSCH

State Medical Board of Ohio

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

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
CERTIFICATION OF TRAINING PROGRAM

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

YODER, Betty
OBSTETRICS AND GYNECOLOGY

MPLETED BY APPLICANT

Name of Applican

Middle | Suffix (Jr., II)

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: Cleveland Clinic

Training Program Address: 9500 Euclid Avenue
Street Address

Cleveland | Oh | 44195
City | State | Zip Code

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

Specialty
(*see reverse side*):

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

Dates of Training
(not to exceed one year):

Beginning Date: MO/DAY/YR 7/1/12

Ending Date: MO/DAY/YR 6/30/13

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

HOSPITAL SEAL

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

Signature of Medical Director or Program Director

Elias Traboulsi, M.D.
Name (please print)

3/21/2012
Date

MEDICAL BOARD
MAR 22 2012

THIS FORM CANNOT BE FAXED

State Medical Board of Ohio

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

EMPLOYER/TRAINING PROGRAM RECOMMENDATION FORM

Dr. Betty Monique Yoder

is applying for a training certificate in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for the training certificate. **To ensure processing of the physicians application please complete and return this form to the State Medical Board of Ohio at the above address, within two (2) weeks. The form can also be faxed to the Board at (614) 644-1464.** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known him/her? 2 years

(2) What is/was your supervisory capacity? attending OBGYN for Jr/Sr Med Students

(3) At what hospital? Avera Sacred Heart in Yankton, SD

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

(5) In your opinion is he/she a person of good moral and ethical character? Absolutely yes

(6) Does he/she work well with peers and medical staff? very well

(7) Does he/she relate well to patients? very well

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

(9) Would you recommend him/her for a training certificate to participate in a training program in Ohio? without reservation

Additional comments, please: (If needed, an extra sheet of paper may be used)

Sincerely,

Gina Bouldware
Licensure Examiner

Signature of Physician

RT Ferrell, MD
Name of Physician (please type or print clearly)

Assoc. Prof Ob/Gyn Sanford School of Medicine Yankton, SD 57078
Position

605-665-5538
Telephone number (include area code)

State Medical Board of Ohio

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

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

THIS FORM IS NOT TO BE COMPLETED PRIOR TO GRADUATION

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

THIS SECTION TO BE COMPLETED BY APPLICANT

Full Name: Yoder (Last) Betty (First) Monique (Middle) (Suffix (Jr., II))

Name of Medical/Osteopathic School: Sanford School of Medicine University of South Dakota

Location: Vermillion (City) SD (State)

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

Betty Monique Yoder (Signature of Applicant) 4/16/12 (Date)

THIS SECTION TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that **Yoder** (Last) **Betty** (First) **Monique** (Middle) (Suffix (Jr., II))

attended medical/osteopathic school From: **08 / 08** (month/year) To: **05 / 12** (month/year)

This individual *(check one)*:

☑ was awarded the degree of **Doctor of Medicine** on **05 / 04 / 2012** (month/day/year)

☐ was not awarded a degree (please attach an explanation)

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

AFFIX INSTITUTIONAL SEAL

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

Kay L Austin (Signature)

Kay L. Austin (Name (please print))

Registration Officer (Title)

5/18/12 (Date)

MEDICAL BOARD
MAY 24 2012

THIS FORM CANNOT BE FAXED

10/9/2012

Betty Monique Yoder, MD
Cleveland Clinic Foundation
c/o GME-NA-23
9500 Euclid Avenue
Cleveland OH 44195

NUMBER: **57 . 021543**
HOSPITAL: **Cleveland Clinic Foundation**
Obstetrics & Gynecology

DATES: **07/01/2012 - 06/30/2013**

Dear Doctor:

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

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

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

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

Sincerely,
Gina Bouldware
Gina Bouldware
Licensure Examiner

Date Posted: 6/18/2013 5:41:34 PM

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

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

Address Information

MAIN

2820 Mayfield Rd.
Apt. 404
Cleveland Heights, OH 44108
Cuyahoga County
United States of America
605-670-2746
moniqueyoder@hotmail.com

License Information

License Number	57.021543
License Name	Betty Yoder

Fees

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

TC-Change programs

1. Are you training at the program listed, **OR**, have you been appointed to the program listed for the next training year?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

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

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

Date Posted: 6/3/2014 10:35:13 AM

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

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

Address Information

MAIN

2820 Mayfield Rd.
Apt. 404
Cleveland Heights, OH 44118
Cuyahoga County
United States of America
605-670-2746
yodermonique@gmail.com

License Information

License Number 57.021543
License Name Betty Yoder

Fees

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

TC-Change programs

1. Are you training at the program listed, **OR**, have you been appointed to the program listed for the next training year?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

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

Date Posted: 5/27/2015 8:16:16 AM

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

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

Address Information

MAIN

6437 Westminster Drive
Parma, OH 44129
Cuyahoga County
United States of America
605-670-2746
yodermonique@gmail.com

License Information

License Number	57.021543
License Name	Betty Yoder

Fees

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

TC-Change programs

1. Are you training at the program listed, **OR**, have you been appointed to the program listed for the next training year?

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

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

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

Ohio State Medical Board of Ohio

med.ohio.gov | 30 East Broad Street, 3rd Floor, Columbus, Ohio 43215-6127 | (614) 466-3934

Affidavit Form

Name on Current License: Betty Monique Yoder
Ohio License Number: 57.021543
Branch of Practice: OB/Gyn
Current Mailing Address: 10437 Westminster Drive
Parma, OH 44129

Email Address: yoderb@ccf.org

☐ **Check Box if New Information**

I, Monique Yoder Katsuki, am requesting a replacement duplicate identification card:
(Name of Licensee/Affiant)

☒ **Name Change Only - No Fee (include a copy of legal name change document)**

☐ **Wall Certificate – Fee $35 (fee payable to the Ohio Treasurer - check or money order only)**

For the following reason (i.e., lost, stolen, damaged, name change, etc.): Name Change

NAME AS IT SHOULD APPEAR ON YOUR IDENTIFICATION CARD:

LAST	FIRST	MIDDLE	SUFFIX (JR/SR)
Katsuki	Monique	Yoder	

Affiant further states that the statement herein contained is strictly true in every respect; that he/she is the person named in the original identification card and was the lawful possessor of the original identification card; and that if his/her identification card has been lost and is later found, he/she will return the original identification card to the State Medical Board of Ohio at 30 E. Broad Street, Columbus, Ohio 43215-6127, ATTN: Records Department.

I SWEAR OR AFFIRM THAT THE ABOVE AND FOREGOING REPRESENTATIONS ARE TRUE AND CORRECT TO THE BEST OF MY INFORMATION, KNOWLEDGE, AND BELIEF.

Monique Yoder Katsuki	2/8/2016
Signature	**Date**

STATE OF Ohio
COUNTY OF Lorain

I, the undersigned Notary Public, do hereby affirm that Monique Yoder Katsuki, personally appeared before me on the 8th day of February 20 16, and signed and sworn the above Affidavit of free act and deed.

Notary Signature

Melinda A. Feldkircher
Printed Name and Commission Expiration/ Stamp

NOTARIAL SEAL STATE OF OHIO

MELINDA A. FELDKIRCHER
Notary Public, State of Ohio
Lorain County
My Commission Expires
July 2, 2018
(NOTARY SEAL)

MEDICAL BOARD

FEB 11 2016

Please return this completed form, applicable fee and documentation to the Records Department at the address on this letterhead

Rev. 9/29/2015 perHB64, Sec. 4731.071

MELINDA A. FELDKAMPER
Notary Public, State of Ohio
Lorain County
My Commission Expires
July 2, 2018

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

MEDIC

FEB 11 2016

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

(11/01/2000)