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Board of Registration in Medicine

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License ☒ Initial Full License ☐ Administrative License ☐ Volunteer License

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

REDACTED COPY

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

CANNON RACHEL

Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☐ PhD ☐ Other degree_____ ☐ Male ☒ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here. ☐

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Social Security Number: _ _ _ _ _ _ _ _ _ Date of Birth: ____ ____ ____ Month Day Year

NPI (National Provider Identifier) Number: 1407198617

Place of Birth: _____ City State/Province/Territory Country if not USA

*Mailing Address: _____ Number and Street _____ Telephone: _____

_____ City State/Province/Territory Zip (or postal) Code

Home Address: _____ Number and Street _____ Telephone: _____

_____ City State/Province/Territory Zip (or postal) Code

Business Address: _____ Number and Street Telephone: _____

_____ City State/Province/Territory Zip (or postal) Code

E-mail Address: _____ Fax number: _____

Are you applying for licensure through FCVS? ☐ Yes ☒ No

* The Board will use your Mailing Address for all correspondence

Pre-medical School From To

Name: Boston University Degree: B.S Year: 2004 Year: 2008

Street: 1 Silber Way City: Boston State: MA

Name: _____ Degree: _____ Year: _____ Year: _____

Street: _____ City: _____ State: _____

Medical School

Name: University of Massachusetts Medical School Degree: MD

Street: 55 North Lake Ave City: Worcester State: MA

Name: _____ Degree: _____

Street: _____ City: _____ State: _____

Medical School Graduation Date: 06 / 2013
Month Year

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

From To

Facility: McGaw Medical Center Northwestern PGY Year: 1 - 4 06 / 13 06 / 17 (PC 2/22/17)

Specialty: OBGYN City: Chicago State: IL

Facility: _____ PGY Year: _____ ___/___ ___/___

Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ ___/___ ___/___

Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ ___/___ ___/___

Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ ___/___ ___/___

Specialty: _____ City: _____ State: _____

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination.

Examination	Number of attempts	Passed (P) or Failed (F)
USMLE Step I	1	☒ P ☐ F
USMLE Step II	1	☒ P ☐ F
USMLE Step III	1	☒ P ☐ F
NBME Part I		☐ P ☐ F
NBME Part II		☐ P ☐ F
NBME Part III		☐ P ☐ F
FLEX Component 1		☐ P ☐ F
FLEX Component 2		☐ P ☐ F
FLEX Pre-1985		☐ P ☐ F
NBOME Part I		☐ P ☐ F
NBOME Part II		☐ P ☐ F
NBOME Part III		☐ P ☐ F
COMLEX Level 1		☐ P ☐ F
COMLEX Level 2		☐ P ☐ F
COMLEX Level 3		☐ P ☐ F
COMVEX		☐ P ☐ F
LMCC – Single		☐ P ☐ F
LMCC – Part I		☐ P ☐ F
LMCC – Part II		☐ P ☐ F
State Board Exam	(State of examination and year)	☐ P ☐ F

Hospital Affiliations and Employment

List hospital appointments, in chronological order by month and year where you ever had medical staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: Prentice Women's Hospital	Position: Resident	7 / 2013	/ present
Street: 250 East Superior St	City: Chicago	State: IL	
Facility: Stroger Hospital	Position: Resident	7 / 2013	/ present
Street: 1901 West Harrison St	City: Chicago	State: IL	
Facility:	Position:	/	/
Street:	City:	State:	

1. List other states (abbreviations) where you are currently or have ever had a full license: ____ ____ ____

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s): ____

4. List your practice specialt(ies): OB GYN

5. Have you completed the Opioid and Pain Management training? (See Instructions) ☒ Yes ☐ No

6. Have you completed training to recognize and report suspected child abuse or neglect? ☑ Yes ☐ No
   (Your license will not be processed until you complete the required training – see instructions.)

7. Reason for requesting a Massachusetts medical license: Fellowship at Boston University Medical Center

8. Name of Facility: Boston University Medical Center
   Address: 1 Boston Medical Center Place City: Boston

9. Anticipated starting date in Massachusetts: 07 / 01 / 2017

10. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete.

Signature of Applicant

12 / 27 / 2016
Month Day Year

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
www.mass.gov/massmedboard

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, RACHEL CANNON
(type/print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations and their representatives to release information, records, transcripts and other documents concerning my professional qualifications and competency, ethics, character and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents, and records be sent directly to:

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

Rachel Cannon
Applicant's Signature

11/18/2016
Date of Signature

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

Applicant's Date of Birth (month/day/year)

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

____ Participation in a Meaningful Use program as an eligible professional;
_X_ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
____ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
____ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

____ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
____ for an Administrative License;
____ for a Volunteer License;
____ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
____ for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: Renee Quinn DATE: 11/22/2016

Rachel Cannon, MD

RESIDENCY

06/13-06/17 **McGaw Medical Center of Northwestern University** RC 2/12/17
Chicago, IL
OB/GYN Residency Training Program

EDUCATION

08/09 – 06/13 **University of Massachusetts Medical School** RC 2/12/17
Worcester, MA
M.D., June 2013

08/04 – 06/08 **Boston University**
Boston, MA
B. S. in Human Physiology, Magna Cum Laude RC 2/12/17

MEDICAL LICENSURE

2013 – present Illinois Temporary Medical License (125063039)

HONORS/AWARDS

2016 Nominated to be Chief Administrative

2014, 2015 Resident Teaching Award (Recognized among top resident teachers by medical students)

2014 Nomination for Goldsmith Award, (Hospital-wide Humanity award for first year intern among all specialties)

PEER-REVIEWED PUBLICATIONS

M Thomenius, C D Freel, S Horn, R Krieser, E Abdelwahid, **R Cannon**,S Balasundaram, K White and S Kornbluth "Mitochondrial fusion is regulated by Reaper to modulate Drosophila programmed cell death" *Cell Death Differ* 2011 Oct; 18(10):1640-50.

WORK EXPERIENCE

2008-2009 **Cutaneous Biology Research Center of Massachusetts General Hospital**
Boston MA
Lab Technician
- Managed lab supply ordering
- Maintained *Drosophila* fly stocks
- Assisted post-doctoral fellows with experiments including PCR and microdissection and staining of *Drosophila* embryos and embryonal structures
- Preformed independent research projects

PROFESSIONAL SOCIETY MEMBERSHIPS

2015- present **Society for Family Planning**

2013 - present **American College of Obstetricians and Gynecologists**

2010 - present **Medical Students for Choice**

2009 - present **American Medical Association**

PERSONAL

, Travel

PRINT NAME: RACHEL CANNON DATE: 11 / 18 / 2016

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS		YES	NO
1.	While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
2-A.	Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B.	Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?		
3.	If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

PRINT NAME: RACHEL CANNON DATE: 11/18/2016

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
10.	Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		
11.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
14-A.	Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: RACHEL CANNON DATE: 11/16/2016

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 15 - 17. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application; it means recently enough to impact one's functioning as a physician.

		YES	NO
15.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
16.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
17.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: RACHEL CANNON DATE: 11/18/2016

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board's regulations, 243 CMR 1.00 through 3.00.

I certify under the penalties of perjury that all information on this form, and all attached pages, is true, to the best of my knowledge.

Applicant's Signature: Rachel Cannon Date: 11/18/2016

Seal Verified
DATE: 1/4/17
INITIALS:

Sealed Envelope
Initials:

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for at least one year and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts. **The form must be notarized by a U.S. Notary Public.**

PHOTOGRAPH

ed.

e

olic.

Signature of applicant

I certify that the photograph above is a genuine likeness of the maker of the signature above.

Signature of Notary

2/11/20
My commission expires

SANDRA L KLEIN
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
February 11, 2020

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

This certifies that I have been personally acquainted with the physician named below:

Rachel Cannon
(name of applicant)

for 4 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of Certifying Physician

036097572 — License Number
IL — State

Susan E. Gerber
Type or print name clearly

Address: 250 East Superior St

City: Chicago State: IL Zip: 60611

Telephone: (312) 472-4685

Date: 12/30/2016

***Instructions to the certifying physician**: Please answer every question, date this form, and return it to the applicant in a sealed envelope with your signature across the seal.*

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

Sealed Envelope Initials:

MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. Please note: Fourth year medical students must include the letter to the medical school registrar and Form B.

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: _____ Date of Birth: ____ ____ ____

Name (Please type or print): CANNON (Last Name) RACHEL (First Name) _____ (Middle Initial)

Other Name(s) (Please type or print.): _____

Name of Medical School: University of Massachusetts Medical School

Address: 55 N Lake Ave City: Worcester State or Province: MA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A. For fourth year medical graduates, please complete Form B after the student completes the degree requirements. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above-named institution when applicant attended, please enter name below:

_____

Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Boston University

Undergraduate School Address: One Silber way Boston MA 02215

Enrollment and Participation:

Our records indicate that Cannon (Last name) Rachel (First name) _____ (Middle Initial)
(Print the applicant's name):

attended our medical school for a total of 162 weeks (must be included) of continuous medical education on the following dates from 08 / 12 /2009 (month/day/year) to 06 / 02 /2013 (month/day/year).

This applicant:

Check one: ☒ was awarded the degree of Doctor of Medicine on 06 / 02 /2013 (month/day/year)

☐ will be awarded the degree of _____ on ____/____/____ (month/day/year)
(Form B must also be completed and returned directly to the Board.)

☐ was not awarded a degree because: _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. If you answer "YES" to any of the questions below, please enclose an explanation.

	YES	NO
1. Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates, or did the applicant take any leaves of absence (i.e. for research, public service, participation in an M.D./Ph.D. program) or for any "personal reasons"?		
2. Was the applicant ever placed on probation or remediation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

Please provide a detailed explanation for any of the above questions _____

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized.)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Michael F. Baker

Print Name: Michael F. Baker, M.A.

Title: Registrar

Date: 11 /22 /2016 Telephone: (508) 856-2267

E-mail address: registrar@umassmed.edu

This form must be stamped with the institutional seal or notarized. Please return to the applicant with the medical school transcripts in a sealed envelope with the signature of the Dean or the seal of the medical school affixed on the back of the envelope. Thank you.

Seal Verified
DATE: 11/29/16
INITIALS:

Sealed Envelope Initials:

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: [signature] Date: 12/30/2016

Print or Type Name: Rachel Cannon

Name and Address of Institution: 250 East Superior St McGaw Medical Center of Northwestern
Chicago IL 60611

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**.

Name of Institution: McGaw Medical Center of Northwestern

Name of Institution, if different when applicant attended: _____

Verification for: Rachel Cannon
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	PGY (1,2,3,4, etc.)	Department or Type of Specialty Training (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	Dates Attended (Month/Day/Year) FROM	TO	Completed (Yes/No/In Progress)	Accredited by (ACGME, AOA, RSC, or not accredited)
Internship	1	OB/Gyn	6/24/13	6/29/14	Yes	ACGME
Residency	2	OB/Gyn	6/30/14	6/29/15	Yes	ACGME
Residency	3	OB/Gyn	6/30/15	6/29/16	Yes	ACGME
Residency	4	OB/Gyn	6/30/16	6/29/17	In Progress	ACGME
			/ /	/ /		

Report incomplete training levels (years) 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.

APPLICANT'S NAME: Rachel Cannon

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **If you answer "yes" to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

COMMENTS: _____

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: [signature]

Print Name: Susane. Gerber, MD

Academic Title: Program Director

Telephone: (312) 472-4673 Today's Date: 12/30/16

E-mail address: Sgerber@northwestern.edu

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

SANDRA L KLEIN
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
February 11, 2020

Seal Verified
DATE: 1/4/17
INITIALS: