122600

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)
MARCHIN	ANGELA	LYNN	

Maiden Name Or Other Names Used (If none, enter "NONE"):

Last (Surname)	First	Middle	Suffix (Jr., II)

Physicians Address (Be sure to notify the Board of any change in address):

Number & Street			
54231 Shady Lane			
City	**State**	**Zip Code**	**Country**
Shelby Township	MI	48315	USA

TRAINING PROGRAM INFORMATION

Ohio Training Program Address (Hospital in Ohio where you will be starting your training):

Hospital & Department		
The Ohio State University / Mt. Carmel Health - OB/GYN		
Number & Street		
395 W. 12th Avenue, 5th Floor		
City	**State**	**Zip Code**
Columbus	OH	43210

Dates of Training: Beginning Date: Mo/Day/Yr 6/24/13 Ending Date: Mo/Day/Yr 6/30/17

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	City	State	Country
Michigan State University College of Human Medicine	East Lansing	MI	USA

Dates Attended: From: Mo/Yr 08/09 To: Mo/Yr 05/13

Degree Received: MD Date Received Mo/Day/Yr 5/11/13

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

School Name	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	Name of Medical School	City	State	Country

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

ECFMG CERTIFICATE

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To be completed by International medical school graduates only:

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

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

Applicant Name: Angela Marchia Date: 4-15-13

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 9 / 1 / 87

Birth Place: City Warren State NJ Country USA

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

PHYSICAL DESCRIPTION

Height 5' 4"

Weight 115

Hair Color Blonde

Eye Color Green

Identifying Marks _____

Date Photo Taken: ___/___ 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*
			☐ 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: Angela Marchini Date: 4-15-13

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 MEDICAL BOARD MAY 15 2013	%Clinical %Admin.

Applicant Name: Angela Marchis Date: 4-15-13

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 MAY 15 2013	%Clinical %Admin.

Applicant Name: Angela Marchin Date: 4-15-13

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?	☐	☒

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Applicant Name: Angela Marchio Date: 4-15-13

		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: Angela Marchin Date: 4-15-13

		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.

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		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.	☐	☐

Applicant Name: Angela Marchin Date: 4-15-13

"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.

		YES	NO
	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: Angela Marchin Date: 4-15-13

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):_____

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.

_____

_____

_____

_____

_____

_____

_____

Angela Marchin
Physician's Signature

4-15-13
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 in English. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

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ss STATE OF: Michigan

COUNTY OF: Macomb

I, Angela Marchio, 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.

Angela Marchio
Signature of Applicant

Subscribed and sworn to before me this 16th day of April 20 13.

Kevin D. Kosa
Signature of Notary Public

(NOTARY SEAL)

7/3/2018
Date Commission Expires

THIS FORM CANNOT BE FAXED

State Medical Board of Ohio

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

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
CERTIFICATION OF TRAINING PROGRAM

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

THIS SECTION TO BE COMPLETED BY APPLICANT

Name of Applicant: Marchin (Last) Angela (First) (Middle) (Suffix (Jr., II))

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

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

Training Program Address: 395 W. 12th Avenue, 5th Floor
Street Address

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

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

Specialty (*see reverse side*): OBGYN

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

Dates of Training ***(not to exceed one year)***: Beginning Date: MO/DAY/YR 6/24/13 Ending Date: MO/DAY/YR 6/30/14

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)

Philip Samuels, MD
Signature of Medical Director or Program Director

Philip Samuels, MD
Name (please print)

5/9/13
Date

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THIS FORM CANNOT BE FAXED

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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: Marchin (Last) Angela (First) Lynn (Middle) (Suffix (Jr., II))

Name of Medical/Osteopathic School: Michigan State University - College of Human Medicine

Location: East Lansing (City) MI (State)

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

Signature of Applicant: Angela Marchin Date: 4/13/13

THIS SECTION TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that Marching, Angela L. (Last, First, Middle, Suffix (Jr., II))

attended medical/osteopathic school From: 8 / 2009 (month/year) To: 5 / 2013 (month/year)

This individual (check one):

☒ was awarded the degree of M.D. on 5 / 3 / 2013 (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.

Signature: Gina L. Brooks

Gina L. Brooks, M.A.
Name (please print)

College Records Officer
Title

March 14, 2013
Date

THIS FORM CANNOT BE FAXED

State Medical Board of Ohio

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

EMPLOYER/TRAINING PROGRAM RECOMMENDATION FORM

Dr. Angela Merchin
(Please provide the applicant's first and last name.)

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) 466-4331.** 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? 1½ years.

(2) What is/was your supervisory capacity? Faculty, clerkship director

(3) At what hospital? Hurley Medical Center

(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? Yes.

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

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

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

(9) Would you recommend him/her for a training certificate to participate in a training program in Ohio? Yes.

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

No concerns.

Sincerely,

Gina Bouldware
Licensure Examiner

Signature of Physician

Laurie A. Carravallah MD FACP FAAP
Name of Physician (please type or print clearly)

Program Director, Combined Med-Peds Residency Hurley Med Ctr
Position

Associate Professor MSU-CHM

Telephone number (include area code)

810 2624283

MEDICAL BOARD
JUN 06 2013

OFFICE USE ONLY
photo attached
privileges attached _

THE OHIO STATE UNIVERSITY Medical Center

Date: 5/31/13

CONFIDENTIAL PEER RECOMMENDATION
EVALUATION FOR MEDICAL STAFF APPOINTMENT/CLINICAL PRIVILEGES

RE: Angela Mardini SPECIALTY: OB-Gyn.

The above named practitioner has made application for appointment or reappointment to the medical/allied health staffs of The Ohio State University Hospitals Health System and has provided your name as a peer reference. A peer reference is one who has trained with or recently worked with the applicant and directly observed the applicant's professional performance over a reasonable period of time and who can provide reliable information regarding the applicant's qualifications for appointment.

We would appreciate your completing all parts of this form and returning it at your earliest convenience to the ***Corporate Credentialing Office @ 700 Ackerman Road, Suite 570 Columbus, OH 43202 or FAX to 614-293-7443.***

Please be advised this information will be kept in strictest confidence by the Credentials Committee and will be used in good faith for the current appointment activity for the above named practitioner.

Our records show that the above-named practitioner was at your institution from 9/11 to 5/13
During that time he/she was

_____ Medical/Dental Staff: Category: _____; _____ Intern _____ Resident _____ Fellowship

_____ Employee _____ Mid-level Practitioner _____ Other: Medical Student.

	Yes**	No	Unknown
VERIFICATION			
If the practitioner was or currently is enrolled in a post-graduate training program, did or will he/she successfully complete the program?		✓	
Comments: Medical Student			
CORRECTIVE ACTION			
Has the practitioner ever been subject to any disciplinary action, such as admonition, reprimand, suspension or termination?		✓	
Comments:			
CONDUCT AND HEALTH STATUS			
Has the practitioner ever shown signs of any drug and/or alcohol related problems?		✓	
Has the practitioner ever shown signs of any mental or physical health problems?		✓	
Comments:			

**If answer is "yes" please provide a comment

MEDICAL BOARD
JUN 06 2013

Name of Applicant:

During what time period did you observe the applicant's clinical practice?
From 9/11 to 5/13

What is your relationship to the applicant: faculty
**Please provide comment for "does not meet expectations"

	Meets Expectations	Does Not Meet Expectations**	Unknown
Gathers essential and accurate information about patients using the following skills:			
Physical Exam	✓		
Diagnostic Studies	✓		
Clinical Information Systems	✓		
Makes informed decisions & therapeutic decisions based on patient information, current scientific evidence & clinical judgment:			
Uses effective and appropriate clinical problem-solving skills	✓		
Understands the limits of one's knowledge and expertise	✓		
Uses consultants and referrals appropriately	✓		
Performs consultations in a timely manner	✓		
Develops and carries out patient management plans	✓		
Obtains informed consent	✓		
Comments:			
MEDICAL KNOWLEDGE			
Uses information technology to optimize patient care	✓		
Critically evaluates current medical information	✓		
Has fund of medical knowledge as related to his/her specific clinical discipline	✓		
Has fund of medical knowledge as related to broad aspects of the practice of medicine	✓		
Comments:			
INTERPERSONAL AND COMMUNICATION SKILLS			
Communicates effectively with patients and families	✓		
Creates a professional/therapeutic relationship with patients	✓		
Communicates and works effectively as a member or leader of health care team	✓		
Maintains medical records that are:			
Comprehensive and accurate	✓		
Timely	✓		
Legible	✓		
Comments:			
PROFESSIONALISM			
Accepts responsibility for patient care, including continuity of care	✓		
Demonstrates integrity, compassion and empathy	✓		
Respects the patient's privacy and autonomy	✓		
Demonstrates accountability and commitment	✓		
Demonstrates responsiveness to needs of patients that supercedes self-interest	✓		
Demonstrates high standards of ethical behavior	✓		
Demonstrates sensitivity and responsiveness to patients' and colleagues' gender, age, culture, disabilities, ethnicity and sexual orientation	✓		
Comments: Outstanding			

MEDICAL BOARD
JUN 06 2013

**Please provide comment for "does not meet expectations"	Meets Expectations	Does Not Meet Expectations**	Unknown
PRACTICE-BASED LEARNING AND IMPROVEMENT			
Takes primary responsibility for lifelong learning to improve knowledge skills & practice performance	✓		
Analyzes own practice experience & recognizes strengths, deficiencies & limits in knowledge and expertise	✓		
Uses evaluations of performance to improve practice	✓		
Locates, appraises & assimilates evidence from scientific studies	✓		
Uses information technology to optimize lifelong learning	✓		

Comments:

SYSTEMS-BASED PRACTICE			
Allocates resources in a cost effective manner	✓		
Actively cooperates with initiatives to reduce medical errors	✓		
Assists patients in dealing with system complexities	✓		
Appropriately utilizes physician extenders and understands their scope of practice	✓		

Comments:

Observation of Clinical Skills: What is your impression of this applicant's competence and experience in the privileges requested on **the enclosed hospital Delineation of Privileges Form**? (No privilege form included for trainees)

☑ Applicant is qualified and competent to perform procedures requested.

☐ Applicant has not demonstrated his/her qualifications and competence in the procedures requested.

Comments: ______

Photo Identification:

	YES	NO
Is the practitioner on the attached photo the same practitioner you completed the above evaluation for?	☐	☐

RECOMMENDATION:

☑ I recommend this applicant highly, without reservation.

☐ I recommend this applicant as qualified and competent.

☐ I recommend this applicant, with the following reservation(s):

☐ I DO NOT recommend this applicant due to:

MEDICAL BOARD
JUN 06 2013

☐ Please call: (___)

Signature: [signature] **Date:** 5/31/13

Printed Name: Laura A. Carravallah MD

Title Organization: Program Director, Combined Med-Peds Residency Associate Professor Mich State U - CHM

Telephone #: 810 2629283

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

THIS FORM IS NOT TO BE COMPLETED PRIOR TO GRADUATION

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

THIS SECTION TO BE COMPLETED BY APPLICANT

Name: Marchin (Last) Angela (First) Lynn (Middle) (Suffix (Jr., II))

Name of Medical/Osteopathic School: Michigan State Univ. College of Human Medicine

Location: East Lansing (City) Michigan (State)

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

Angela Marchin — Signature of Applicant — 9-27-13 — Date

THIS SECTION TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that Marchin, Angela Lynn (Last, First, Middle, Suffix (Jr., II))

attended medical/osteopathic school from 8/31/2009 (mo/day/yr) to 5/3/2013 (mo/day/yr)

This individual *(check one)*:

- ☒ was awarded the degree of Doctor of Medicine on 5/3/2013 (mo/day/yr)
- ☐ was not awarded a degree (please attach an explanation)

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

Gina L. Brooks
Signature

Gina L. Brooks, M.A.
Name (please print)

College Records Officer
Title

October 11, 2013
Date

THIS FORM CANNOT BE FAXED

10/23/2013

Angela Lynn Marchin, MD
Ohio State University Hospitals
c/o Corporate Credentialing Office
700 Ackerman Road Ste #570
Columbus OH 43202

NUMBER: **57 . 023815**
HOSPITAL: **Ohio State University Hospitals**
Obstetrics & Gynecology

DATES: **06/24/2013 - 06/23/2014**

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: 6/9/2014 5:26:00 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.

License Information

License Number	57.023815
License Name	Angela Marchin

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: 6/10/2015 11:22:33 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

1228 Harrison Ave
Columbus, OH 43201
Franklin County
United States of America
(586) 764-7201
angela.marchin@osumc.edu

License Information

License Number 57.023815
License Name Angela Marchin

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: 3/22/2016 7:24:09 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.

License Information

License Number	57.023815
License Name	Angela Marchin

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.

State Medical Board of Ohio

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

VERIFICATION OF LICENSURE/LETTER OF GOOD STANDING

This letter is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 1/24/2017:

Identification Information

Full Name:	Angela Lynn Marchin
Date of Birth:	09/01/1987

License Information

Type of License:	MD Training Certificate
License Number:	57. 023815
Original Licensure Date:	10/23/2013
Expiration Date:	06/23/2017
Status:	Active
Formal Action(s)*:	No

Sincerely,

A.J. Groeber
Executive Director

If there is a formal board action against this licensee and you need additional information or to receive certified copies of a public record, please send a written request to Med-PublicRecordRequests@med.ohio.gov detailing the nature of your subsequent inquiry. The online system makes certain scanned documents related to board actions taken on all Ohio licensees available to the public via the website at www.med.ohio.gov .

For general license verification questions, send an email to med.renewal@med.ohio.gov. All communications to the Board must include the name of the licensee and license number with each request.