Uniform Application for Licensure

Application ID: 270649
FID: 215383258
License Requested: MD
Submitted to: Kansas State Board of Healing Arts
Submission Date: 01/25/2019

Practitioner Name

Fink, Geetha Narayani

Alternate Name(s): Vivekaandamorthy, Geetha Narayani

Contact Information

Address

Public Access	Board Contact	Type	Address
No	No	Home	[redacted] UNITED STATES
Yes	Yes	Business	5107 E. Kellogg Dr Wichita Wichita, KS 67218 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	Yes	Business	(316) 260-6934	
No	No	Mobile	[redacted]	

Email

Public Access	Board Contact	Email
Yes	Yes	geetha.fink@gmail.com

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
	[redacted]	[redacted]	Beverly Hills, CA UNITED STATES	F		MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Rosalind Franklin University of Medicine and Science	3333 Green Bay Road North Chicago, IL 60064 UNITED STATES	08/01/2005	06/04/2010	06/04/2010	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Uniform Application – Core Application

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Applicant: Follow the instructions given in the left sidebar of each page.
Send this application to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Indicate your full legal name and any other names you have used in the past. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change to the Board.

Full Name

Last name: Fink Suffix: _____

First name: Geetha

Middle name: Narayani

Maiden name (if applicable): Vivekaandamorthy.

All other names used/identified as: _____

Degree Type ☑ M.D. ☐ D.O.

Please complete all fields and Indicate which address you want to use for public access and at which address you want to receive mailings from the Board. State laws vary on which address or phone number is or is not a matter of public record. Additionally, many state boards publish the Public Access address on their web sites. You may wish to contact the appropriate state licensing authority to determine which information will be a matter of public record.

Practice Address

☑ Public Access
☐ Mailings for Medical Board

Street: 5107 E. Kellogg Dr.

City: Wichita

State/Province: KS

Zip code: 67218 Country: USA

Practice phone: 316-260-6934 Practice fax: 316-425-3451

Alternate phone: 316-425-3215 Alternate fax: _____

Practice email: geetha.fink@gmail.com

Home Address

☐ Public Access
☑ Mailings for Medical Board

Street: [redacted]

City: [redacted]

State/Province: [redacted]

Zip code: 98166 Country: USA

Home phone: [redacted] Home fax: _____

Alternate phone: _____ Alternate fax: _____

Home email: geetha.fink@gmail.com

If you are not using FCVS, you must submit one of the following to the Board: certified birth certificate, notarized copy of your birth certificate, original valid passport, or notarized copy of your current valid passport. Please check the state specific instructions for more information.

Be sure to list your name at the top of each following page.

Identification

Date of birth: [redacted] Gender: F Birth city: Beverly Hills

Birth state/province: CA Birth country: USA

Social Security number*: [redacted] (9 digits) NPI number**: 1982919437 (10 digits) U.S. Citizen? ☑ Yes ☐ No

*Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 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. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

**The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, visit http://www.cms.hhs.gov/NationalProvIdentStand/

Postgraduate Training

Hospital Name:	**Creighton University School of Medicine/Maricopa Medical Center (Phoenix) Progra** Phoenix, AZ UNITED STATES	**Program Code:**	ACGME 2200321328
		Attendance Dates:	
Institution:	Creighton University School of Medicine	**Start Date:**	07/01/2011
Training Specialty:	Obstetrics & Gynecology	**End Date:**	06/30/2015
		Program Type:	Residency
Training Status:	Completed		

Hospital Name:	**Icahn School of Medicine at Mount Sinai** New York, NY UNITED STATES	**Program Code:**	
		Attendance Dates:	
Institution:		**Start Date:**	07/01/2015
Training Specialty:	Family Planning	**End Date:**	06/30/2017
		Program Type:	Fellowship/Research
Training Status:	Completed		

Hospital Name:	**Los Angeles County-Harbor-UCLA Medical Center Program** Torrance, CA UNITED STATES	**Program Code:**	ACGME 4400521056
		Attendance Dates:	
Institution:	Los Angeles County-Harbor-UCLA Medical Center	**Start Date:**	07/01/2010
Training Specialty:	Surgery	**End Date:**	06/30/2011
		Program Type:	Internship
Training Status:	Completed		

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		06/11/2007	Pass	1
USMLE Step 2 CK Examination		08/27/2008	Pass	1
USMLE Step 2 CS Examination		01/20/2010	Pass	1
USMLE Step 3 Examination		06/11/2012	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
New York State Board for Medicine	NY	279805	05/15/2015	10/31/2018	Full	Inactive
Washington Medical Quality Assurance Commission	WA	MD60760977	06/16/2017	11/09/2019	Full	Active

Applicant Name: Geetha Fink

List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

*Also list your permanent or home address for each non-working time.

If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.

DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS SECTION.

Copy and attach additional pages as necessary.

** Clinical indicates the percentage of time spent with patients.

*** Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

Chronology of Activities

1. Start date: 07/2010 (mm/yyyy) End date: 06/2011 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☑ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: Preliminary internship General Surgery - Harbor UCLA.

Street: 1000 W. Carson St.

City: Torrance State/Province: CA Zip code: 90509.

Country: USA Position: Intern.

Department: General Surgery. Clinical**: 100% Administrative***: ____%

☑ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

2. Start date: 07/2011 (mm/yyyy) End date: 06/2015. (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☑ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: OBGYN Residency. Phoenix Integrated Residency in Obstetrics & Gynecology

Street: 2601 E. Roosevelt St.

City: Phoenix State/Province: AZ Zip code: 85008.

Country: USA. Position: Resident Physician.

Department: OBGYN. Clinical**: 100% Administrative***: ____%

☑ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

3. Start date: 07/2015. (mm/yyyy) End date: 06/2017. (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: Fellowship in Family Planning

Street: 1176 5th Ave

City: New York. State/Province: NY Zip code: 10029.

Country: USA Position: Fellow - Physician

Department: OBGYN Clinical**: 100% Administrative***: ____%

☑ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

Applicant Name: Geetha Finle

Copy and attach additional pages as necessary.

4. Start date: 07/2017. (mm/yyyy) End date: 09/2017. (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☑ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: Transition period between Fellowship and new job.

Street: 3629 36th Ave S. Unit A.

City: Seattle. State/Province: WA Zip code: 98144.

Country: USA. Position: Unemployed.

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

5. Start date: 09/2017. (mm/yyyy) End date: Current. (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☑ Work

Practice/Employment Name **or** Description of non-working time*: Hospitalist Laborist Medmax. - work @ Swedish First Hill Hospital

Street: 1229 Madison St. #750.

City: Seattle State/Province: WA Zip code: 98104.

Country: USA. Position: Laborist

Department: Obstetrics Clinical**: ____% Administrative***: ____%

☑ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

6. Start date: 11/2017. (mm/yyyy) End date: Current (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: Trust Women Seattle

Street: 1325 4th Ave. #1240

City: Seattle State/Province: WA Zip code: 98101.

Country: USA Position: Gynecologist.

Department: Gynecology. Clinical**: 100% Administrative***: ____%

☑ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): Independent Contractor.

Please copy and attach additional pages as necessary.

Applicant Name: Geetha Fink

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Copy and attach additional pages as necessary.

~~4.~~ 7. Start date: 05/2015. (mm/yyyy) End date: 06/2018. (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☑ Work

Practice/Employment Name **or** Description of non-working time*: Per Diem OBGyn. Hospitalist: Highline Medical Center.

Street: 16251 Sylvester Rd. SW.

City: Burien State/Province: WA. Zip code: 98166.

Country: USA. Position: Hospitalist

Department: OBGyn. Clinical**: 100. % Administrative***: ____%

☑ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

~~5.~~ 8. Start date: 07/2018. (mm/yyyy) End date: Current. (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☑ Work

Practice/Employment Name **or** Description of non-working time*: Per Diem OBGyn. Provider: St. Francis Hospital.

Street: 34515 9th Ave S.

City: Federal Way. State/Province: WA. Zip code: 98003

Country: USA. Position: Physician.

Department: OBGyn Clinical**: 100 % Administrative***: ____%

☑ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

~~6.~~ Start date: _____ (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

Please copy and attach additional pages as necessary.

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
None Reported						

Chronology of Activity Type

Practice/Emp/ Desc: **Trust Women Seattle**
Chronology Type: Work

Address: 1325 4th Ave
Suite 1240
Seattle
Seattle, WA 98101
US

Attendance Dates:
Position/Dept: Physcian - Physcian
Start Date: 08/01/2017
End Date: In Progress
Clinical %: 90
Admin %: 10

Employment: ● **Staff Privileges:** ○ **Affiliation:** ○

Practice/Emp/ Desc: **Swedish Hospital**
Chronology Type: Work

Address: 1229 S. Madison
Seattle, WA 98101
US

Attendance Dates:
Position/Dept: Laborist - Labor and Delivery
Start Date: 07/01/2017
End Date: 01/01/2019
Clinical %: 85
Admin %: 15

Employment: ○ **Staff Privileges:** ● **Affiliation:** ○

Practice/Emp/ Desc: **Planned Parenthood NYC**
Chronology Type: Work

Address: 26 Blecker ST
New York, NY 10012
US

Attendance Dates:
Position/Dept: Physician - Provider
Start Date: 01/01/2016
End Date: 06/01/2017
Clinical %: 90
Admin %: 10

Employment: ● **Staff Privileges:** ○ **Affiliation:** ○

Practice/Emp/ Desc: **Icahn School of Medicine at Mount Sinai**
Chronology Type: Other Training

Address: New York, NY
US

Attendance Dates:
Position/Dept:
Start Date: 07/01/2015
End Date: 06/30/2017
Clinical %:
Admin %:

Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **Creighton University School of Medicine/Maricopa Medical Center (Phoenix) Progra**
Chronology Type: Accredited Training

Address: Phoenix, AZ
US

Attendance Dates:

Position/Dept:

Start Date: 07/01/2011

End Date: 06/30/2015

Clinical %:

Admin %:

Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **Los Angeles County-Harbor-UCLA Medical Center Program**

Chronology Type: Accredited Training

Address: Torrance, CA
US

Attendance Dates:

Position/Dept:

Start Date: 07/01/2010

End Date: 06/30/2011

Clinical %:

Admin %:

Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **Rosalind Franklin University of Medicine and Science**

Chronology Type: Medical Education

Address: North Chicago, IL
US

Attendance Dates:

Position/Dept:

Start Date: 08/01/2005

End Date: 06/04/2010

Clinical %:

Admin %:

Employment: **Staff Privileges:** **Affiliation:**

Malpractice

None Reported

Applicant Name: Geetha Fink

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

☑ I have not had any malpractice claims or suits made against me.

1. Name of patient involved: _____

In which state, territory, or province did the action take place? _____

Which court*? _____

Case number (if applicable) _____ Month and year of lawsuit: _____

Month and year of event precipitating claim: _____

Current claim status: ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Open (pending) ☐ Other: _____

Amount of judgment or settlement: $_____ Amount paid on your behalf: $_____

What is/was your status? ☐ Primary Defendant ☐ Co-Defendant ☐ Other (specify): _____

Insurance carrier at the time: _____

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

Complete the forms on the following pages as instructed.

☑ UA Affidavit and Authorization for Release of Information
☑ UA Form #1: Licensure Verification Form → FSMB/FCVS
☑ All state-specific forms included with this core application

If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

☐ UA Form #2: Medical School Verification
☐ UA Form #3: Postgraduate Training Verification
☐ UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

Applicant Name: Geetha Fink

List all medical schools you have attended, even those from which you did not graduate, in chronological order. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Medical Education Verification form and send it to all medical schools you have attended. Include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to the Board.

Additionally, the medical school must provide the Board with an official copy of your transcripts. If transcripts are not in English, an original, certified, and official English translation is required.

If you attended a Fifth Pathway program and are not using FCVS, you must complete the Fifth Pathway Verification form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical School and institution must forward all documentation directly to the Board.

If ECFMG is applicable and you are not using FCVS, contact ECFMG and have a certified status report forwarded from them to the Board. There is a separate fee for this report.

Medical School

1. Full Name of Medical School: Chicago Medical School, Rosalind Franklin University
   Street: 3333 Green Bay Rd.
   City: North Chicago State/Province: IL Zip code: 60064
   Country: USA. Attendance dates: From 08/2005 (mm/yyyy) to 06/2010. (mm/yyyy)
   Date degree conferred/issued (indicate if not applicable): 06/04/2010. (mm/dd/yyyy)
   Degree received (as stated on diploma): Medical Degree. (indicate if not applicable)

2. Full Name of Medical School: Keck School of Medicine, University of So. California
   Street: 1975 Zonal Ave,
   City: Los Angeles State/Province: CA Zip code: 90033
   Country: USA. Attendance dates: From 08/2008. (mm/yyyy) to 05/2010. (mm/yyyy)
   Date degree conferred/issued (indicate if not applicable): _____ (mm/dd/yyyy)
   Degree received (as stated on diploma): Masters of Public Health (indicate if not applicable)

Fifth Pathway

☑ I did not participate in a Fifth Pathway program.

Affiliated medical school that awarded the Fifth Pathway Certification

Full Name of Medical School: _____
Street: _____
City: _____ State/Province: _____ Zip code: _____
Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)
Date degree conferred/issued: _____ (mm/dd/yyyy) Degree (as stated on diploma): _____

Hospital or clinic in which you performed the required rotations

Institution name: _____
Rotation dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Certificate date: _____ (mm/dd/yyyy)

ECFMG

☑ I do not have an ECFMG certificate.

Certificate number: _____ Issue date: _____ (mm/dd/yyyy)

Applicant Name: Geetha Fink

List all postgraduate programs you have attended, even those you did not complete. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Postgraduate Training Verification form and send it to all postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to the Board. The postgraduate program must forward all documentation directly to the Board.

Postgraduate Training

1. Full Name of Hospital: Harbor UCLA Medical Center.
Street: 1000 W. Carson St.
City: Torrance. State/Province: CA Zip code: 90509
Country: USA. Department/Specialty: General Surgery.
Affiliated medical school name:
Attendance dates: From 07/2010 (mm/yyyy) to 06/2011 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 1.

☐ Chief Resident ☐ Internship/Residency ☐ Residency ☐ Transitional
☐ Fellowship ☐ Junior Registrar ☐ Residency/Chief Residency
☐ Fellowship/Research ☑ Preliminary ☐ Senior House Officer ☐ Unknown
☐ House Officer ☐ Registrar ☐ Senior Registrar ☐ Unspecified
☐ Internship ☐ Research ☐ Other:

Successfully completed? ☑ Yes ☐ No ☐ In progress; expected completion in (mm/yyyy)

2. Full Name of Hospital: Phoenix Integrated Residency in Obstetrics & Gynecology
Street: 2601 E. Roosevelt St.
City: Phoenix State/Province: AZ. Zip code: 85008.
Country: USA. Department/Specialty: Obstetrics & Gynecology
Affiliated medical school name:
Attendance dates: From 07/2011 (mm/yyyy) to 07/2015 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 1-4.

☐ Chief Resident ☑ Internship/Residency ☐ Residency ☐ Transitional
☐ Fellowship ☐ Junior Registrar ☐ Residency/Chief Residency
☐ Fellowship/Research ☐ Preliminary ☐ Senior House Officer ☐ Unknown
☐ House Officer ☐ Registrar ☐ Senior Registrar ☐ Unspecified
☐ Internship ☐ Research ☐ Other:

Successfully completed? ☑ Yes ☐ No ☐ In progress; expected completion in (mm/yyyy)

3. Full Name of Hospital: Mount Sinai Hospital
Street: 1 Gustave Levy Pl.
City: New York. State/Province: NY. Zip code: 10029
Country: USA. Department/Specialty:
Affiliated medical school name: Icahn School of Medicine
Attendance dates: From 07/2015 (mm/yyyy) to 06/2017 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 5-6

☐ Chief Resident ☐ Internship/Residency ☐ Residency ☐ Transitional
☐ Fellowship ☐ Junior Registrar ☐ Residency/Chief Residency
☑ Fellowship/Research ☐ Preliminary ☐ Senior House Officer ☐ Unknown
☐ House Officer ☐ Registrar ☐ Senior Registrar ☐ Unspecified
☐ Internship ☐ Research ☐ Other:

Successfully completed? ☑ Yes ☐ No ☐ In progress; expected completion in (mm/yyyy)

Applicant Name: Geetha Enki

List the information for each licensure exam you have taken, whether U.S. or international (USMLE, LLMCC, NBME, etc.).

If you are not using FCVS, you must contact the appropriate examination entity and have them send a certified transcript of your scores directly to the Board.

Examination History

Examination	Most recent date taken (mm/yyyy)	Passed/Failed/Unknown	Number of attempts
FLEX Pre-1985		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 1		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 2		☐ (P) ☐ (F) ☐ (U)	
LMCC – Single		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part I		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part I		☐ (P) ☐ (F) ☐ (U)	
NBME Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part III		☐ (P) ☐ (F) ☐ (U)	
SPEX		☐ (P) ☐ (F) ☐ (U)	
NBOME Part I		☐ (P) ☐ (F) ☐ (U)	
NBOME Part II		☐ (P) ☐ (F) ☐ (U)	
NBOME Part III		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 1		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, CE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, PE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 3		☐ (P) ☐ (F) ☐ (U)	
COMVEX		☐ (P) ☐ (F) ☐ (U)	
USMLE Step I	06/2007	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CS	01/2010	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CK	08/2008	☑ (P) ☐ (F) ☐ (U)	1
USMLE Step III	06/2012	☑ (P) ☐ (F) ☐ (U)	1
State Board Exam			
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	

List all state and Canadian provinces where you currently hold or have ever held any type of health care related license. Please copy and attach additional pages if necessary.

You must also complete the Licensure Verification form and send it to all states in which you have held any health care license or certification. Some state boards charge a fee for this information. The verifying entity must forward all licensure documentation to the Board.

State/Province Professional Licensure

1. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

☑ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic

☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: WA License number: MD60760477 Issue date: 06/16/17

License status: ☑ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

Applicant Name: Geetha Fink

Please copy and attach additional pages if necessary.

2. Practitioner license type: ☑ Full license ☐ Temporary ☐ Training ☐ Limited

- ☑ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: NY. License number: 279805 Issue date: 05/15/15

License status: ☐ Active ☑ Expired ☐ In Good Standing ☐ Inactive ☐ Limited ☐ Probationary ☐ Restricted ☐ Retired ☐ Revoked ☐ Suspended

3. Practitioner license type: ☐ Full license ☐ Temporary ☑ Training ☐ Limited

- ☑ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: AZ License number: _____ Issue date: 07/2011

License status: ☐ Active ☑ Inactive ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended ☐ Restricted

4. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

- ☐ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Expired ☐ In Good Standing ☐ Inactive ☐ Limited ☐ Probationary ☐ Restricted ☐ Retired ☐ Revoked ☐ Suspended

5. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

- ☐ Doctor of Medicine
- ☐ Doctor of Osteopathic Medicine
- ☐ Doctor of Dental Surgery
- ☐ Doctor of Dental Medicine
- ☐ Doctor of Psychology
- ☐ Doctor of Podiatric Medicine
- ☐ Doctor of Chiropractic
- ☐ Nurse Practitioner
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse
- ☐ Physician Assistant
- ☐ Emergency Medical Technician
- ☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Expired ☐ In Good Standing ☐ Inactive ☐ Limited ☐ Probationary ☐ Restricted ☐ Retired ☐ Revoked ☐ Suspended

FCVS

FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Fink, Geetha Narayani**
Social Security Number:	[redacted]
Date of Birth:	[redacted]
FID#:	**215383258**
Recipient:	**KS - Kansas State Board of Healing Arts**
Delivery Date:	**01/14/2019**

ABOUT THIS PROFILE

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

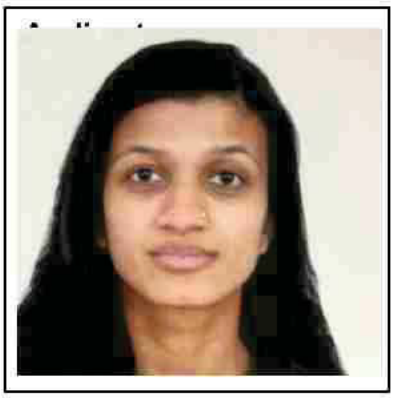
I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect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

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

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

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

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



Geetha Fink
Applicant's Signature (**must** be signed in the presence of a notary)

Fink
Applicant's **Printed** Last Name

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

5/17/2018
Date of Signature (**must** correspond to date of notarization)

LISA SVANDA
ELECTRONIC
NOTARY
PUBLIC
REG # 7338796
EXPIRES
6/30/2018
COMMONWEALTH OF VIRGINIA

State of Virginia, County of Chesterfield,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 17 day of May, 20 18.

Notary Public Signature: Lisa Svanda

My Notary Commission Expires: June 30, 2018

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

fsmb

Biographic Information

Medical professional Name(s): **Fink, Geetha Narayani**

Vivekaandamorthy, Geetha Narayani

Date of Birth: [redacted]

Place of Birth: Beverly Hills, CA, UNITED STATES

Contact Information

Home Address: [redacted]

UNITED STATES

Mobile Phone: [redacted]

Email: geetha.fink@gmail.com

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Fink (Last) Geetha (First) Narayani (Middle)

FCVS ID Number: 215383258

Notary – Please complete the section below:

State of Virginia County of Chesterfield

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 17, of (Month) May, (Year) 2018.

Notary Public Signature: Lisa Svanda

Commission Expiration Date* (Month) June /(Day) 30 /(Year) 2018

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

Notary Stamp Here

LISA SVANDA
ELECTRONIC NOTARY PUBLIC
REG # 7338706
EXPIRES 6/30/2018
COMMONWEALTH OF VIRGINIA

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

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

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE/FIRMA DEL TITULAR

NOT VALID UNTIL SIGNED

PASSPORT
PASSEPORT
PASAPORTE

USA

UNITED STATES OF AMERICA

Type / Type / Tipo: P

Code / Code / Código: USA

Passport No. / No. du Passeport / No. de Pasaporte: [redacted]

Surname / Nom / Apellidos
VIVEKAANDAMORTHY

Given names / Prénoms / Nombres
GEETHA NARAYANI

Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA

Date of birth / Date de naissance / Fecha de nacimiento
[redacted]

Sex / Sexe / Sexo: F

Place of birth / Lieu de naissance / Lugar de nacimiento
CALIFORNIA, U.S.A.

Date of issue / Date de délivrance / Fecha de expedición
08 Aug 2003

Authority / Autorité / Autoridad
Los Angeles
Passport Agency

Date of expiration / Date d'expiration / Fecha de caducidad
07 Aug 2013

Amendments / Modifications / Enmiendas
See Page 24

P<USAVIVEKAANDAMORTHY<<GEETHA<NARAYANI<<<<<<

[redacted]USA8311092F1308079<<<<<<<<<<<<<<02

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
08/01/2005	06/04/2010	Medical Education	Rosalind Franklin University of Medicine and Science North Chicago Illinois UNITED STATES
07/01/2010	06/30/2011	Postgraduate Training	Los Angeles County-Harbor-UCLA Medical Center Program Torrance California UNITED STATES
07/01/2011	06/30/2015	Postgraduate Training	Creighton University School of Medicine/Maricopa Medical Center (Phoenix) Progra Phoenix Arizona UNITED STATES
07/01/2015	06/30/2017	Postgraduate Training	Icahn School of Medicine at Mount Sinai New York New York UNITED STATES

End of Chronology of Activities report for: Fink, Geetha Narayani

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **Rosalind Franklin University of Medicine and Science**

Location: North Chicago, IL
UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

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

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

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

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

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

Institution Name: Rosalind Franklin University of Medicine and Science

Address Line 1: 3333 Green Bay Road

Address Line 2:

City: North Chicago **State/Province:** IL **Zip Code (Postal Code):** 60064

Country: US

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

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

Enrollment and Participation: Our records indicate that Fink, Geetha Narayani
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 156 weeks of medical education on the following dates: **From:** 08/01/2005 **To:** 06/04/2010
Month Day Year Month Day Year

This individual
Was awarded the degree of Doctor of Medicine on 06/04/2010
Month Day Year
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

_____

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

Watermark
For FCVS internal use only.

ELECTRONIC SEAL VERIFIED

Name: Rebecca Durkin

Signature: *Rebecca Durkin*

Title: Registrar
Date of Signature: 12/13/2018 **Phone:** (847) 578-3228
Fax: (847) 775-6559 **Email:** registrar@rosalindfranklin.edu

215383258 1288 215383258

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? **Yes**

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

	From Date:	To Date:	
Personal/Family_____			
Academic remediation_____			
Health _____			
Financial _____			
Participation in joint degree Program (e.g., MD/PhD)			
Participation in non-research special study			
(e.g., fellowship, international experience)_____			
Participation in non-degree research _____	08/18/2008	06/01/2009	Approved
Other:			
Other:			

Please Specify:

Research year

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

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

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

Please specify a reason:

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

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

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

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

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

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Medical School

Medical Professional Name: Fink, Geetha Narayani

Rosalind Franklin University of Medicine and Science

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**Yes**
Dates: 08/2008 To 06/2009	
Took a year off to get Masters in Public Health	
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Fink, Geetha Narayani

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

ROSALIND FRANKLIN UNIVERSITY
OF MEDICINE AND SCIENCE

Chicago Medical School
College of Health Professions
Dr. William M. Scholl College of Podiatric Medicine
School of Graduate and Postdoctoral Studies

Office for Student Affairs
Chicago Medical School

3333 Green Bay Road
North Chicago, IL 60064
Telephone: 847-578-3295
Facsimile: 847-578-3298
www.rosalindfranklin.edu

November 1, 2009

Medical Student Performance Evaluation
for

GEETHA VIVEKAANDAMORTHY

Dear Residency Selection Committee:

Chicago Medical School (CMS) at Rosalind Franklin University of Medicine and Science educates physicians and scientists dedicated to providing exemplary, compassionate patient care and excellence in scientific discovery within an interprofessional environment. CMS strives to instill in every student the incumbent medical and scientific knowledge, skills, attitudes, and values that the field of medicine and society expect of a physician. The following measurable competencies, our touchstones of excellence, reflect this overall goal:

I. Medical and Scientific Knowledge
II. Patient Care and Prevention
III. Professionalism and Self-Awareness
IV. Practice-Based, Life-Long Learning
V. Systems-Based, Interprofessional Practice
VI. Interpersonal and Communication Skills

Our curriculum and student assessments are built around these competencies.

Chicago Medical School students graduating in June, 2010, are required to take and pass Step 1 and Step 2CK of the USMLE. They must sit for USMLE Step 2CS to graduate. The student must give CMS permission to make such scores available.

Our students are graded on a competency based A, B, C, F system for both basic sciences and clinical courses. Overall performance evaluations are reported as follows: outstanding, superior, good and competent. Students whose records are significantly different in the basic sciences versus clinical sciences have summary evaluations for each.

Premedical:

[redacted]

[redacted]

Academic History – Basic Sciences

[redacted]

Academic Progress – Clinical Clerkships

[redacted]

Obstetrics/Gynecology (6 weeks - Mount Sinai Hospital Medical Center):

[redacted]

Psychiatry (6 weeks - Elgin Mental Hospital):

[redacted]

Clinical Neurology (3 weeks - North Chicago VA Hospital):

[redacted]

Pediatrics (6 weeks - Mount Sinai Hospital Medical Center):

[redacted]

Surgery (8 weeks – Advocate Lutheran General Hospital):

[redacted]

[redacted]

Medicine (8 weeks – Advocate Illinois Masonic Medical Center):

[redacted]

Family Medicine (4 weeks – Advocate Lutheran General Hospital):

[redacted]

Emergency Medicine (4 weeks – Stroger Hospital of Cook County):

[redacted]

Summary:

Geetha graduated from the University of California, Los Angeles in 2005 with a double major in Microbiology/Immunology/Molecular Genetics and Religion. She did research in Neuroscience, coordinated events for the Center for the Study of Religion, and traveled to Sri Lanka to volunteer. A long time practitioner of the classic Indian dance form, Bharatanatyam, Geetha performs and facilitated a student organization at UCLA to bring together other dancers.

In 2005 Geetha matriculated at Chicago Medical School. She completed the basic science curriculum on schedule. Over the summer, she continued her involvement in arts programs in the Los Angeles area, and did research at Stanford.

On her required clinical rotations, Geetha earned [redacted] in all of her clerkships. Her attending staff noted her enthusiasm for learning and willingness to work hard. After completing the required third year clinical rotations, Geetha took a year leave-of-absence to begin work on a Master's in Public Health at Keck School of Medicine, University of Southern California. She returned in the summer of 2009 to complete her senior year of medical school.

Based on her medical school record, Geetha Vivekaandamorthy has performed at a **Competent** level in the basic sciences and clinically at a **Good** level in comparison to her peers at the Chicago Medical School.

Sincerely,

Cathy J. Lazarus, MD, FACP
Senior Associate Dean
CMS Student Affairs and
Medical Education

Arthur J. Ross, III, MD, MBA
Vice President for Medical Affairs
Dean, Chicago Medical School

Chicago Medical School at Rosalind Franklin University of Medicine and Science
Class of 2010 Grade Distribution

	Credit Hours	% A	% B	% C
First Year Courses				
Molecular and Cellular Biology	5			
Genetics	3			
Embryology	3			
Anatomy	11			
Histology	5			
Biochemistry	6			
Physiology	14			
Neuroscience	7			
Introduction to Clinical Medicine	4			
Second Year Courses				
Microbiology and Immunology	15			
Pathology	19			
Pharmacology	11			
Clinical Neuroscience	7			
Essentials in Clinical Reasoning	11			
Preventive Medicine	2			
Third Year Clerkships				
Surgery	12			
Medicine (includes 3 weeks of Ambulatory Care)	15			
Family Medicine	6			
Obstetrics/Gynecology	9			
Emergency Medicine	6			
Neurology	4.5			
Pediatrics	9			
Psychiatry	9			

- Grade Distribution is derived from review of senior transcripts and reflects remediated grades where relevant.
- Pass/Fail Courses (Medical Ethics, Epidemiology, Clinical Skills and Sophomore electives) are not included in this listing.

Prepared by
CMS Office for Student Affairs
October, 2009

ROSALIND FRANKLIN UNIVERSITY of MEDICINE AND SCIENCE

DATE ISSUED : 13 Dec 2018
RFU-ID : 0131309
RECORD OF : FINK, GEETHA NARAYANI
ACAD. PROGRAM : MEDICINE

CONFIDENTIAL

ELECTRONIC SEAL VERIFIED

Rosalind Franklin University
of Medicine and Science
3333 Green Bay Road
North Chicago, IL 60064
(847) 578-3228

AN OFFICIAL SIGNATURE IS WHITE WITH A GRAY BACKGROUND

Rebecca L. Durkin, Registrar

ROSALIND FRANKLIN UNIVERSITY *of* MEDICINE AND SCIENCE

DATE ISSUED : 13 Dec 2018
RFU-ID : 0131309
RECORD OF : FINK, GEETHA NARAYANI
ACAD. PROGRAM : MEDICINE

CONFIDENTIAL

ELECTRONIC SEAL VERIFIED

Rosalind Franklin University
of Medicine and Science
3333 Green Bay Road
North Chicago, IL 60064
(847) 578-3228

Rebecca L. Durkin, Registrar

ROSALIND FRANKLIN
UNIVERSITY
of MEDICINE AND SCIENCE

Office of the Registrar
3333 Green Bay Road
North Chicago, IL 60064
(847) 578-3228

Former University Names:
The Chicago Medical School
University of Health Sciences/The Chicago Medical School
Finch University of Health Sciences/The Chicago Medical School

Former Names of Dr. William M. Scholl College of Podiatric Medicine:
Illinois College of Podiatric Medicine
Illinois College of Podiatry
Illinois College of Chiropody & Foot Surgery
Illinois College of Chiropody
Dr. William M. Scholl College of Podiatric Medicine
Dr. William M. Scholl College of Podiatric Medicine
at Finch University of Health Sciences/The Chicago Medical School

Accreditation
Rosalind Franklin University of Medicine and Science receives its degree-granting authority from the Illinois Board of Higher Education and is accredited by the Higher Learning Commission.
Higher Learning Commission
230 South LaSalle Street, Suite 7-500
Chicago, IL 60604
800.621.7440

The University consists of the following five schools:
Chicago Medical School
Dr. William M. Scholl College of Podiatric Medicine
College of Health Professions
School of Graduate and Postdoctoral Studies
College of Pharmacy

Family Educational Rights and Privacy Act
In Accordance with the Family Educational Rights and Privacy Act of 1974, the information on the enclosed transcript is provided with the understanding that the recipient will not allow any other person to have access to this information without the written consent of the student.

Academic Calendar
All schools within Rosalind Franklin University operate under a quarter calendar, and credit is expressed in quarter hours. Prior to 2003, Dr. William M. Scholl College of Podiatric Medicine operated under the semester calendar and credit was expressed in semester hours.

Grading System – Includes grades awarded by all schools of the University. A specific grade may not be valid in a particular school.

A	–	High Achievement
B	–	Above Average Achievement
C	–	Average Achievement
D	–	Below Average, but passing
H	–	Honors
P	–	Pass
HP	–	High Pass (used by Chicago Medical School for third year clinical courses only)
F	–	Fail
W	–	Withdrawal
PP	–	Pass Proficiency Exam
I	–	Incomplete
#	–	Graded at Sequence End
IP	–	In Progress
NR	–	Needs Remediation
NC	–	No Credit given
AU	–	Audit

In addition to the current grading system, prior to Fall 2002, the following notations were used:

AH = 'A' with Honors
DF or Defer = Deficient (this grade is remediable)
#C = Failed/Passed Retake Exam and received a 'C'
#P = Failed/Passed Retake Exam
#F = Failed/Failed Retake Exam
+C = Failed/Passed Retake Course and received a 'C'
+P = Failed/Passed Retake Course
+F = Failed/Failed Retake Course
* = Graded at Sequence End
WP = Withdrawal/Passing
WF = Withdrawal/Failing
R = Registered for Research
Q = Qualified
S = Satisfactory
CT = Credit
+ = Same course as taken by Medical Students

Prior to 1975, Dr. William M. Scholl College issued numerical grades for the didactic courses.
Prior to 1982, Dr. William M. Scholl College used compound grades (e.g. FA, FB, DC); Students took a retake exam in the course; both grades were calculated in grade point average.

Starting 2013, Chicago Medical School initiated Pass Fail grading in the pre-clerkship courses.

Starting in July of 2016, Chicago Medical School initiated Honors/High Pass/Pass/Fail grading in third year clinical clerkships.

United States Medical Licensing Examination (USMLE) Requirement
Prior to 2016, Chicago Medical School required students to pass USMLE Step 1 and USMLE Step 2 Clinical Knowledge (CK) for graduation. Chicago Medical School required students to take USMLE Step 2 Clinical Skills (CS) for graduation.

Starting in 2017, Chicago Medical School requires students to pass USMLE Step 1, USMLE Step 2 Clinical Knowledge (CK), and USMLE Step 2 Clinical Skills (CS) for graduation.

ROSALIND FRANKLIN UNIVERSITY

OF MEDICINE AND SCIENCE

on the recommendation of the Faculty of

The Chicago Medical School

the Board of Trustees has conferred the degree of

DOCTOR OF MEDICINE

upon

Geetha Narayani Fink

who has honorably fulfilled all the requirements for that degree.

Given in the city of North Chicago, Illinois,
this 4th day of June, 2010.

Ruth M. Rothstein
Chair, Board of Trustees

President

Dean

CERTIFIED TO BE A TRUE COPY

REBECCA L. DURKIN, REGISTRAR
STRATEGIC ENROLLMENT MANAGEMENT
ROSALIND FRANKLIN UNIVERSITY OF
MEDICINE AND SCIENCE

ELECTRONIC
SEAL
VERIFIED

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: **4400521056**

Institution: **Los Angeles County-Harbor-UCLA Medical Center Program**

Location: Torrance, CA
UNITED STATES

Accreditation ID: **2200321328**

Institution: **Creighton University School of Medicine/Maricopa Medical Center (Phoenix) Progra**

Location: Phoenix, AZ
UNITED STATES

Accreditation ID: **None**

Institution: **Icahn School of Medicine at Mount Sinai**

Location: New York, NY
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
The Verification of Post Graduate Training Form from Creighton University School of Medicine/Maricopa Medical Center (Phoenix) Program dated 07/01/2011 to 06/30/2015 reported in the Chronology of Activities is not included in the Profile.

Solution(s):
FCVS has made several unsuccessful attempts to obtain the requested elements from the Source.

Issue:
The Verification of Post Graduate Training Form from Icahn School of Medicine at Mount Sinai dated 07/01/2015 to 06/30/2017 reported in the Chronology of Activities is not included in the Profile.

Solution:
FCVS does not obtain verification of non-accredited training programs.

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5099 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: Los Angeles County-Harbor-UCLA Medical Center Program
Specialty: Surgery
Address: Torrance, CA

Attention: **Program Director**
Affiliated University: David Geffen School of Medicine at UCLA

Verification For:

Name: Geetha Narayani Fink
DOB: [redacted]
Individual's Name on Record (If different from above): _____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Block 1
PGY: 1
Specialty/Subspecialty: General Surgery
☑ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
From: 06/24/2010 To: 06/23/2011
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Block 2
PGY: _____
Specialty/Subspecialty: _____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
From: _____ To: _____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Block 3
PGY: _____
Specialty/Subspecialty: _____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
From: _____ To: _____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper

1. Did this individual ever take a leave of absence or break from his/her training?	☐ Yes	☑ No
2. Was this individual ever placed on probation?	☐ Yes	☑ No
3. Was this individual ever disciplined or placed under investigation?	☐ Yes	☑ No
4. Were any negative reports for behavioral reasons ever filed by instructors?	☐ Yes	☑ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ Yes	☑ No

Please explain any "Yes" response from above:

ELECTRONIC SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Angela Neville, M.D. Signature: Angela Neville, M.D.
Title: Director, Residency Program Date of Signature: December 22, 2018
Tel: 310-222-2700 Fax: 310-533-1841 E-Mail: rmmorrison@labiomed.org

Rev. 10/02/2018 FID: 215383258 ACGME ID: 4400521056 GME CODE: _____

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Fink, Geetha Narayani
Accreditation ID:	4400521056
Institution:	Los Angeles County-Harbor-UCLA Medical Center Program
Specialty:	Surgery

Unusual Circumstances

Training Period: 7/1/2010 - 6/30/2011 **Internship**

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

End of Applicant Reported Unusual Circumstances report for: Fink, Geetha Narayani

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

Los Angeles County Harbor-UCLA Medical Center

This Certifies that

Geetha Narayani Fink, M.D.

has served faithfully and satisfactorily as

First Year in General Surgery

at Harbor-UCLA Medical Center, Torrance, California, during the period from

June 24, 2010 to June 23, 2011

In Testimony Whereof this Diploma is herewith granted

BOARD OF SUPERVISORS/COUNTY OF LOS ANGELES

DIRECTOR OF HEALTH SERVICES

CHIEF EXECUTIVE OFFICER

CHIEF MEDICAL OFFICER

PRESIDENT PROFESSIONAL STAFF ASSOCIATION

TRAINING PROGRAM DIRECTOR

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Fink, Geetha Narayani
Accreditation ID:	2200321328
Institution:	Creighton University School of Medicine/Maricopa Medical Center (Phoenix) Progra
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/2011 - 6/30/2015 **Residency**

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

End of Applicant Reported Unusual Circumstances report for: Fink, Geetha Narayani

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

Phoenix Integrated Residency in Obstetrics and Gynecology at Maricopa Medical Center & St. Joseph's Hospital and Medical Center

Phoenix, Arizona

Be it known that

Geetha Narayani Fink, M.D., M.P.H.

has successfully completed Graduate Medical Education in

Obstetrics and Gynecology Residency

From 6/18/2011 Through 6/30/2015

MARICOPA INTEGRATED HEALTH SYSTEM
www.mihs.org

In Testimony Whereof the undersigned have hereto affixed their signatures and the Seal of St. Joseph's Hospital and Medical Center, Phoenix, Arizona on this

Thirtieth Day of June, 2015

Dignity Health.
St. Joseph's Hospital and Medical Center

Associate Program Director

Program Director

Vice President of Academic Affairs, Maricopa Medical Center

Director, Academic Affairs, St. Joseph's Hospital and Medical Center

President and Chief Executive Officer
Maricopa Medical Center

President and Chief Executive Officer
St. Joseph's Hospital and Medical Center

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

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

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

Date: 01/14/2019

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 386060

Examinee: Fink, Geetha Narayani
Alt Name(s): Vivekaandamorthy, Geetha Narayani

Examinee ID: 5-190-227-8
Date of Birth: [redacted]

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

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/11/2007	Pass	[redacted]	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/27/2008	Pass	[redacted]	(184)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
01/20/2010	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/11/2012	Pass	[redacted]	(190)	

End of Exam History

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

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

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

Examinee: Fink, Geetha Narayani

Examinee ID: 5-190-227-8
Date of Birth: [redacted]

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

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

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

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

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

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

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

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

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

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

03/2015

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

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:1/14/2019

PRACTITIONER INFORMATION

Name:	Fink, Geetha Narayani
Alternate Name(s):	Vivekaandamorthy, Geetha Narayani
DOB:	[redacted]
Medical School:	Rosalind Franklin University of Medicine and Science North Chicago, Illinois, UNITED STATES
Year of Grad:	2010
Degree Type:	MD
NPI:	1982919437

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NEW YORK	279805	05/15/2015	10/31/2018	01/09/2019
WASHINGTON	MD60760977	06/16/2017	11/09/2019	12/31/2018

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:1/14/2019
Practitioner Name:	Fink, Geetha Narayani	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

NPDB Report

FINK, GEETHA NARAYANI **DCN: 5500000142584022**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts

Process Date: 1/14/2019

[redacted] CONFIDENTIAL

FINK, GEETHA NARAYANI

[redacted]

[redacted] CONFIDENTIAL

[redacted]

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Maricopa Medical Center
Address: 2601 E. Roosevelt Street
Phoenix, AZ 85008

Attention: **Program Director**
Affiliated University: ____

Verification For:

Name: **Fink (Vivekaandamorthy), Geetha Narayani**

DOB [redacted]

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

Program Participation:

Important:
Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 1-4 (e.g., 1, 2, 3, etc.)
☐ Internship
☑ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: Obstetrics and Gynecology
From: 06/16/2011 **To:** 06/30/2015
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: ____ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: ____ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☑ No
2. Was this individual ever placed on probation? ☐ Yes ☑ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☑ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☑ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☑ No

Please explain any "Yes" response from above:

____

____

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Robert Brady, MD
Signature: [signature]
Institutional Title of Signatory (e.g., Program Director): Program Director
Date of Signature: 01/14/2019
Tel: 602.344.5084 Fax: 602.344.5894
E-Mail: Robert.Brady@dignityhealth.org

Rev. 0[illegible] Packet ID:____ Request ID: ____ IFM CODE[ ]

Massey, Theresa [BOHA]

From: Suzzon Wilson <swilson@fsmb.org>
Sent: Wednesday, January 16, 2019 4:44 PM
To: Schlesener, Nichole [BOHA]
Cc: Massey, Theresa [BOHA]
Subject: GEETHA NARAYANI FINK - FID: 215383258
Attachments: Fink Narayani Geetha 1.14.2019.pdf1.pdf

Importance: High

[redacted]
CONFIDENTIAL
CONFIDENTIAL
[redacted]
CONFIDENTIAL
[redacted]

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

February 19, 2019

KANSAS STATE BOARD OF HEALING ARTS
800 SW JACKSON
TOPEKA, KS 66612

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon License for GEETHA NARAYANI FINK.

You may see blank sections because we do not have the information in our database or it is not applicable for this credential type. This information is valid from the date of this letter.

Year of Birth:	CO
Credential Number:	NFI MD.MD.60760977
Credential Type:	Physician And Surgeon License
Current Credential Status:	ACTIVE
First Credential Date:	06/16/2017
Current Expiration Date:	11/09/2019
Last Renewal Date:	10/17/2017
DISCIPLINARY ACTION:	C O

This license information was last updated on: 02/19/2019

If you have questions, please call (360)-236-2750 or visit our Online Provider Credential Search at https://wmc.wa.gov

THE SEAL OF THE STATE OF WASHINGTON 1889

Kimberly M. Romero, Licensing Manager

Moon, Rebekah [BOHA]

From: support@veridoc.org
Sent: Tuesday, February 19, 2019 3:04 AM
To: KSBHA_InitialLicense
Subject: License Verification Statement - Fink, Geetha
Attachments: v644767AA.pdf

[redacted] CONFIDENTIAL [redacted]

[redacted]

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.
Program Director or Designated Official: Complete as instructed in the left sidebar.

RECEIVED
APR 08 2019
KSBHA

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

Section 1: Applicant Information

Last name: Fink Suffix: _____

First name: Geetha

Middle name: Narayani

Name if different when diploma awarded: _____

Name of postgraduate training program: Icahn School of Medicine Mount Sinai Family Planning

Date of birth: [redacted] Social Security number*: [redacted]

The social security number is to be used for purposes of identification only and may not be used for any other reason.

Waiver for Release of Information: I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts
Mailing address: 800 SW Jackson, Lower Level – Suite A
City/State/Zip: Topeka, KS 66612

Applicant signature: _____ **Date:** 3/27/19

Dean or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

Section 2: Postgraduate Training Verification

Institution name: ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI

Institution address: ONE GUSTAVE L. LEVY PLACE, BOX 1170

Institution city / state or province / zip code: NEW YORK, NY 10029

Affiliated medical school name: ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI

Institution / school name if different when the applicant attended: _____

Postgraduate year (e.g., 1, 2, 3, etc.): 5 ☐ Internship ☐ Residency ☑ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: FAMILY PLANNING

Attendance dates: From 7.1.2015 to 6.30.2016

Successfully completed*? ☑ Yes ☐ No ☐ In progress with expected completion date of _____

In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC
☐ RCPSC ☐ APPAP ☒ None of these

Applicant Name: Geetha Fink

Postgraduate year (e.g., 1, 2, 3, etc.): 6 ☐ Internship ☐ Residency ☑ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: FAMILY PLANNING

Attendance dates: From 7.1.2016 to 6.30.2017

Successfully completed*? ☑ Yes ☐ No ☐ In progress with expected completion date of _____

In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

RECEIVED APR 12 2019 KSBHA

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☒ None of these

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☐ No
2. Was this individual ever placed on probation? ☐ Yes ☐ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☐ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☐ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? ☐ Yes ☐ No

Seal Verified KSBHA

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE

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

Signature: _____

Print name: BRITT LUNDE, MD

Title: FELLOWSHIP PROGRAM DIRECTOR

Date: 4/12/19

Phone number: 212-241-1901 Fax number: 212-987-6386

Email: britt.lunde@mssm.edu

Dept of OB&GYN
1176 5TH AVE - 9TH Floor
New York, NY 10029

NEW YORK NY 100
02 APR 2019 PM 12 L

Kansas State Board of Healing Arts.
800 SW. Jackson, Lower Level. Suite A
Topeka, KS 66612

RECEIVED
APR 08 2019
KSBHA

66612$1244 C006


Seal Verified KSBHA

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this to the state board you are applying to for licensure, NOT to FCVS/FSMB.

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to the board you are applying to for licensure. See http://www.fsmb.org/policy/contacts for a directory of state medical boards.

DO NOT SEND THIS FORM TO FCVS/FSMB. Doing so will delay your licensure process.

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

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

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

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

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

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

Geetha Fink
Applicant's signature (must be signed in the presence of a notary)

Fink
Applicant's printed last name

Geetha Narayani
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

5/17/2018
Date of signature (must correspond to date of notarization)

-fold up- -fold up-

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of Virginia, County of Chesterfield,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 17 day of May, 20 18.

Notary Public Signature: Lisa Svanda

My Notary Commission Expires: June 30, 2018

LISA SVANDA NOTARY PUBLIC ELECTRONIC REG # 7338796 EXPIRES 6/30/2018 COMMONWEALTH OF VIRGINIA

(NOTARY PUBLIC SEAL)

RECEIVED 3/26/2019

ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

Select the discipline applying for and the license designation being requested.

☑ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

☑ Active

A license issued to a person authorizing the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Applicants for active licensure must provide evidence of professional liability insurance (which will be in effect as of the date of licensure) in compliance with Kansas law before a license will be issued. Each active license may be renewed annually. Licensees must maintain and submit evidence of satisfactory completion of a program of continuing education. Licensees must maintain and submit evidence of professional liability insurance, and contribute to the Kansas Health Care Stabilization Fund (more information about this fund can be found here: https://hcsf.kansas.gov/).

☐ Federal Active

A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ Inactive

A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

☐ Exempt

A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

List intended professional activities: _____

Additional Information and Statement of Health:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☑ No
2. Give location of intended practice in Kansas Trust Women 5107 E Kellogg Dr Wichita KS 67218
3. Primary Specialty Obstetrics & Gynecology

   American Board Certified no American Board Eligible yes
4. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your particular branch of the healing arts or your particular specialty? CONFIDENTIAL

   If yes, applicant shall file with this application a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

From: Geetha Fink
To: Brown, Tammy [BOHA]
Subject: Re: KANSAS MISSING REQUIREMENT LETTER
Date: Tuesday, March 26, 2019 4:05:03 PM
Attachments: Addendum 1 Updated.pdf

CONFID
ENTIAL

[redacted]

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CONFIDENTIAL

[redacted]

ADDENDUM 2
KANSAS STATE BOARD OF HEALING ARTS

Please answer each of the following questions by putting a check (✓) in the appropriate box. All "yes" answers MUST be thoroughly explained in detail in a separate signed page. You are required to furnish complete details including date, place, reason and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.

If you are unsure of your response to a particular question, check (✓) the "yes" box and submit the appropriate form if required. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check (✓) the "no" box. It is your continuing duty to update the Board on any changes once the application has been submitted.

1. ☐ Yes ☑ No Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training or educational program, including but not limited to medical school, prior to completing the training?

2. ☐ Yes ☑ No Have you ever had any application for any professional license refused or denied by any licensing authority?

3. ☐ Yes ☑ No Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?

4. CONFIDENTIAL Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

5. ☐ Yes ☑ No Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

6. ☐ Yes ☑ No Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?

7. ☐ Yes ☑ No Have you ever voluntarily surrendered any professional license?

8. CONFIDENTIAL Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation, or had any other disciplinary action taken against any professional license you have held?

9. ☐ Yes ☑ No Have you ever been notified or requested to appear before a licensing or disciplinary agency?

10 CONFIDENTIAL To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?

11 ☐ Yes ☑ No Has any professional association imposed any disciplinary action against you?

[redacted]

17. ☐ Yes ☑ No Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?

18. ☐ Yes ☑ No Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?

19. ☐ Yes ☑ No Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?

20. ☐ Yes ☑ No Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

21 ☐ Yes ☑ No Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

22. ☐ Yes ☑ No Have you ever been court-martialed or discharged dishonorably from the armed services?

23. ☐ Yes ☑ No Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself?

24. ☐ Yes ☑ No Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?

25. ☐ Yes ☑ No Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company?

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): Geetha Fink **Date of Birth:** [redacted]

Please mail this document to the Kansas State Board of Healing Arts at the address above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. Geetha Fink (type or print) for 1.5 years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. Geetha Fink is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Katherine Eastwood Profession: MD Physician

Street 1: [redacted]

Street 2:

State/Zip: [redacted]

Telephone: [redacted]

Signature:

Date: 3/1/2019

RECEIVED
MAR 05 2019
KSBHA

[redacted]

SEATTLE WA 980

01 MAR 2019 PM 7 L

Kansas State Board of Healing Arts
800 SW Jackson, Lower ~~Level~~ Suite A
Topeka, KS 66612

RECEIVED
MAR 05 2019
KSBHA

66612-124473

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): Geetha Fink **Date of Birth:** [redacted]

Please mail this document to the Kansas State Board of Healing Arts at the address above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. Geetha Fink. (type or print) for 18mos years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. Geetha Fink is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Tanya Sorensen Profession: Physician

Street 1: [redacted]

Street 2: [redacted]

State/Zip: [redacted]

Telephone: [redacted]

Signature:

Date: 3/1/19

[redacted]

SEATTLE WA 980

01 MAR 2019 PM 7 L

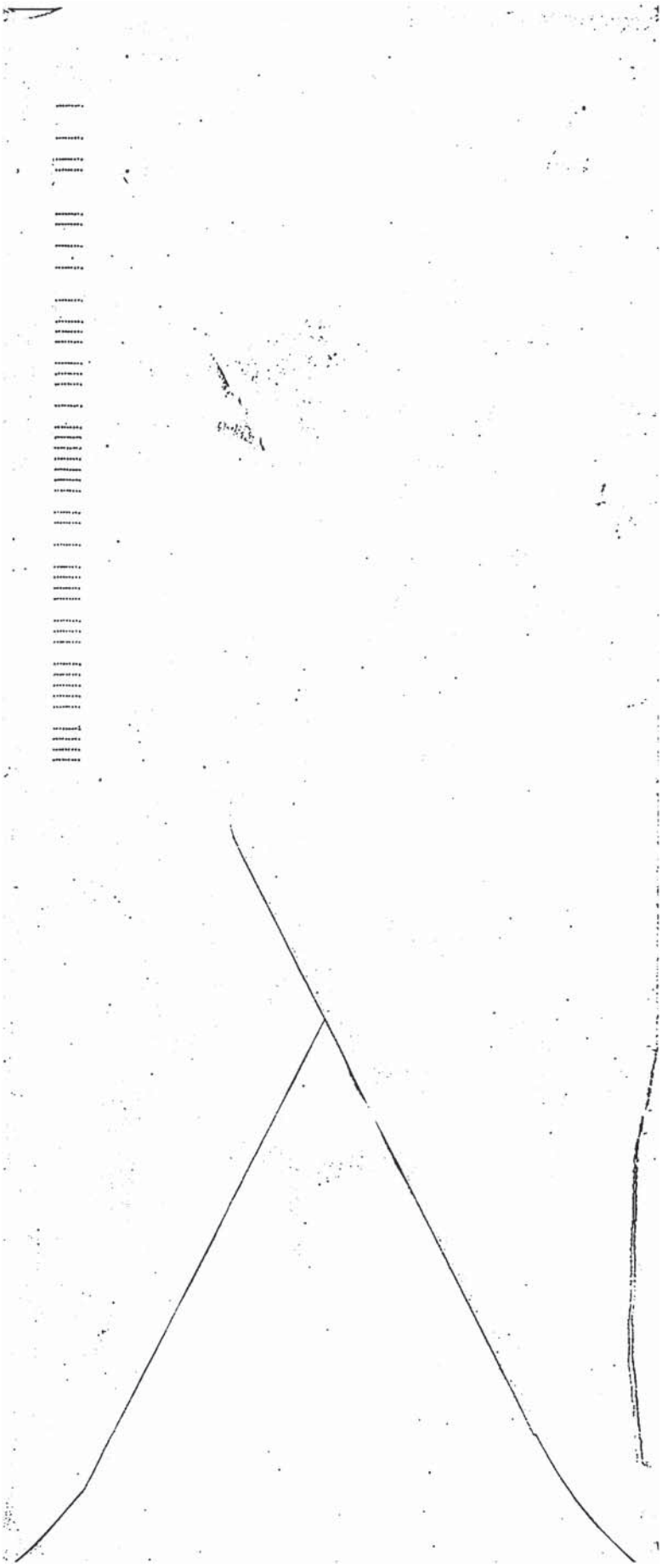
RECEIVED

MAR 05 2019

KSBHA

Kansas State Board of Healing Arts.
900 SW Jackson, Lower Level Suite A
Topeka, KS 66612.

66612-123199



PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Uniform Application for Physician State Licensure	As of Date:1/25/2019

PRACTITIONER INFORMATION

Name:	Fink, Geetha Narayani
Alternate Name(s):	Vivekaandamorthy, Geetha Narayani
DOB:	[redacted]
Medical School:	Rosalind Franklin University of Medicine and Science North Chicago, Illinois, UNITED STATES
Year of Grad:	2010
Degree Type:	MD
NPI:	1982919437

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NEW YORK	279805	05/15/2015	10/31/2018	01/23/2019
WASHINGTON	MD60760977	06/16/2017	11/09/2019	12/31/2018

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Uniform Application for Physician State Licensure	As of Date:1/25/2019
Practitioner Name:	Fink, Geetha Narayani	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

AMA Physician Profile

PREPARED FOR

Kansas State Board of Healing Arts, Topeka, KS

Name and Mailing Address

GEETHA NARAYANI FINK

[redacted]

Birth date [redacted]

Primary Office Address

SAME AS MAILING ADDRESS

Phone UNKNOWN

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1982919437	08/09/2010	NOT RPTD	NOT RPTD	NOT RPTD	03/15/2019

Current and/or historical medical school

CHICAGO MEDICAL SCHOOL AT ROSALIND FRANKLIN UNIVERSITY-MEDICINE & SCIENCES

Degree Awarded: YES
Degree Year: 2010

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution: MARICOPA MEDICAL CENTER
Sponsoring State: ARIZONA
Program name: CREIGHTON UNIVERSITY SCHOOL OF MEDICINE/MARICOPA MEDICAL CENTER (PHOENIX) PROGRAM
Specialty: OBSTETRICS & GYNECOLOGY
Training Type:
Dates: 6/2011 - 6/2015 (Verified)

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 0

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.

Certificate:
Certificate type:

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

Current and/or historical medical licensure

License No.	MD / DO	Jurisdiction	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported
MD60760977	MD	WA	06/16/2017	11/09/2019	10/17/2017	ACTIVE	UNLTD	04/01/2019
60279805	MD	NY	05/15/2015	10/31/2018		INACTIVE	UNLTD	10/04/2018

Action Notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice.

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration Date	Last Reported Date	Address
XXXXXX267	22N 33N 4 5	09/30/2020	03/25/2019	[redacted]

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

ECFMG Certfication

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

Profile Information

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission(AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

RECEIVED 3/29/2019

TRUST WOMEN

TRUST WOMEN
P.O. Box 3222
Wichita, KS 67201
O: 316.425.3215
F: 316.425.3451 (all entities)
info@itrustwomen.org
www.trustwomen.org

TRUST WOMEN
OKLAHOMA CITY
1240 S.W. 44th St.
Oklahoma City, OK 73109
405.429.7940
oklahomacity@itrustwomen.org

TRUST WOMEN SEATTLE
1325 Fourth Ave.
Suite 1240
Seattle, WA 98101
206.625.0202
seattle@itrustwomen.org

TRUST WOMEN WICHITA
5107 E. Kellogg Dr.
Wichita, KS 67218
316.260.6934
wichita@itrustwomen.org

March 29, 2019

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612

[redacted] CONFIDENTIAL

[redacted]

[redacted]

[redacted]

From: Lizeth Lucio
To: Brown, Tammy [BOHA]
Cc: Geetha Fink; Julie Burkhart
Subject: RE: Malpractice
Date: Friday, March 29, 2019 1:38:12 PM
Attachments: image001.png
Letter to Kansas board of healing arts.pdf

[redacted] CONFIDENTIAL [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

CONFIDENTIAL

[redacted]

[redacted]

[redacted]

From: Lizeth Lucio <LLucio@itrustwomen.org>
Sent: Friday, March 29, 2019 11:49 AM
To: Brown, Tammy [BOHA] <Tammy.Brown@ks.gov>
Cc: Geetha Fink <geetha.fink@gmail.com>; Julie Burkhart <jburkhart@itrustwomen.org>
Subject: Malpractice

CONFIDENTIAL

[redacted]

CONFIDENTIAL

[redacted]

[redacted]

[redacted]

TRUST WOMEN

[redacted]

RECEIVED
By KSBHA at 1:56 pm, Apr 04, 2019

KAMMCO

On Behalf of Kansas Health Care
Provider Insurance Availability Plan

LETTER OF INTENT

April 4, 2019

Kansas State Board of Healing Arts
800 S.W. Jackson, Lower Level, Ste A
Topeka, KS 66612

RE: Geetha N. Fink, MD

CONFIDENTIAL

[redacted]

P.O. Box 357 Topeka, KS 66601-0357
785.232.4740

KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

PO Box 357, Topeka, KS 66601-0357
785.232.4740 • 785.232.4704 (Fax)

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance hereby authorizes applicant's present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connections with any claim of professional liability to release to the Company, upon its request, information, which in the judgment of any such carrier, attorney, or the Company, may have a bearing upon applicant's acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which applicant is or has been a member, all hospitals in which applicant now holds or has held staff privileges, the Kansas State Board of Healing Arts and any other state licensing board in which applicant has practiced, the Kansas Department of Health and Environment and any other similar agency in which applicant has practiced or resided, and any and all physicians having information regarding the undersigned, to release to the Company, upon its request, any information any such persons or entity may have, which in the judgment of any such person or entity of the Company, may have a bearing upon applicant's acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants and employees and the Company, its directors, officers, employees, agents and member from any liability arising out of the release or use of any information released or furnished pursuant to this authorizations, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorizations, which shall be of equal validity with the signed original.

Name Geetha N. Fink

Address 5107 E. Kellogg Dr.

Wichita, KS 67218

Signed _____ Date 3/2/19

From: Sara Patry
To: Barnes, Lori [BOHA]; Bohannon, Ronda [BOHA]
Subject: Geetha N. Fink, MD - letter of intent attached
Date: Thursday, April 4, 2019 11:04:59 AM
Attachments: 2019_04_04_11_03_43.pdf

[redacted]

CONFIDENTIAL

[redacted]

[redacted]

[redacted]

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[redacted]

[redacted]

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[redacted]

[redacted]

[redacted]

OFFICIAL RECEIPT
KANSAS BOARD OF HEALING ARTS
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612
(785) 296-7413

RECEIPT NUMBER: 580732
580734
580736

DATE: 02/26/2019

NAME:	LICENSE TYPE:	FEE:	LIC #:
Geetha Narayani Fink	Applic	300.00	03-09-19
Geetha Narayani Fink	KBI	47.00	03-09-19
Geetha Narayani Fink	NPDB	3.00	03-09-19

AMOUNT: 350.00 TYPE: Credit Card CH/CC #: 012021

RECEIVED FROM:

Geetha Narayani Fink

[redacted]

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level - Suite A
Topeka, KS 66612

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level, Suite A
Topeka, KS 66612

Phone: 785/296-7413
Toll Free: 888/886-7205
www.ksbha.org

KANSAS
BOARD OF HEALING ARTS

KANSAS LICENSURE APPLICATION ADDENDUM INSTRUCTIONS MEDICINE & SURGERY (MD) and OSTEOPATHIC MEDICINE & SURGERY (DO)

Please visit www.ksbha.org for all statutes and regulations

Completing the Kansas Licensure Addendum

Complete each addendum as instructed. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Kansas State Board of Healing Arts at the address above.

☑ **Addendum 1** These questions must be completed by the applicant.

☑ **Addendum 2** Each question must be completed by the applicant. Documentation must be provided for any "yes" answer(s). **It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.**

☐ **Addendum 3** Sent separately by recommendation writers

The applicant's full name and date of birth should be printed in the spaces provided on both pages. Two (2) recommendations by licensed physicians that can attest to the applicant's good moral character, and who have known the applicant for at least one year are required. The completed forms must be **returned directly to the Board.** Two (2) forms have been provided for your convenience.

~~☐ **Addendum 4**~~ FCVS

This form must be completed by the applicant. All applicants for licensure in the State of Kansas must request a disciplinary inquiry report from the Federation of State Medical Boards (FSMB). Once this form has been completed, you may email it to the FSMB at boardinquiry@fsmb.org.

If you are using FCVS, do not complete this form. They will obtain your disciplinary report and send it to the Board.

☑ **Addendum 5** ~~sent separately~~ by mail

Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks. Addendum 5 explains in detail how to obtain and submit fingerprints to the Board.

Be aware that fingerprint processing may delay your application. Please make it a PRIORITY to complete the fingerprint process. Complete, sign and return the *Waiver Agreement and Statement* form directly to the Board.

☐ **Credit Card Payment Authorization Form** This form should be used by applicants for payment of the Kansas application fee by credit card. Please enter the required information and return the form directly to the Board at the address above.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

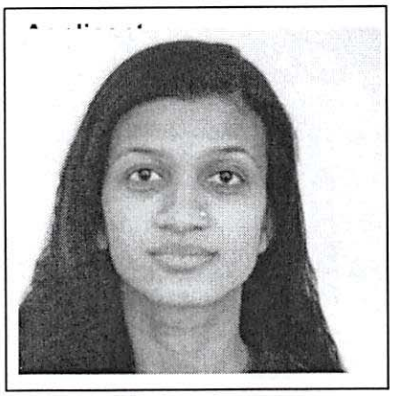
I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect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

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

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

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

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



Geetha Fink
Applicant's Signature (**must** be signed in the presence of a notary)

Fink
Applicant's **Printed** Last Name

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

5/17/2018
Date of Signature (**must** correspond to date of notarization)

LISA SVANDA
ELECTRONIC
NOTARY
PUBLIC
REG # 7338796
EXPIRES
6/30/2018
COMMONWEALTH OF VIRGINIA

Seal Verified KSBHA

State of Virginia, County of Chesterfield,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.
The statements on this document are subscribed and sworn to before me by the applicant on this 17 day of May, 20 18.

Notary Public Signature: Lisa Svanda

My Notary Commission Expires: June 30, 2018

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

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

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Fink (Last) Geetha (First) Narayani (Middle)

FCVS ID Number: 215383258

Notary – Please complete the section below:

State of Virginia County of Chesterfield

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 17, of (Month) May, (Year) 2018.

Notary Public Signature: Lisa Svanda

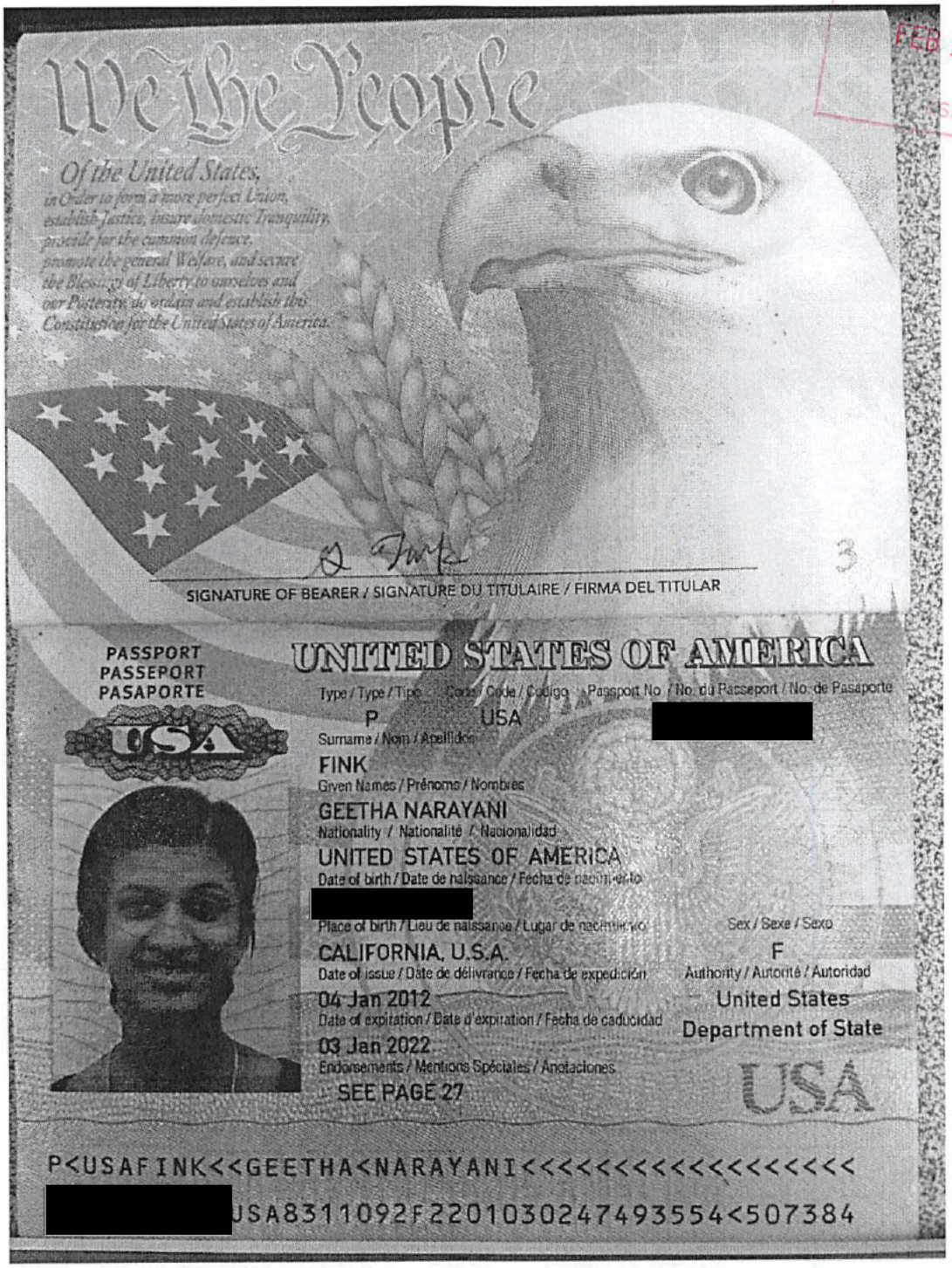
Commission Expiration Date* (Month) June /(Day) 30 /(Year) 2018

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

Notary Stamp Here

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

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



Addendum 5

Kansas

INSTRUCTIONS FOR REQUESTING A CRIMINAL BACKGROUND CHECK

Effective January 1, 2009, applicants to practice the healing arts will be required to submit their fingerprints for state and national criminal history background checks.

Following is the *Waiver Agreement and FBI Privacy Act Statement*. Please complete, sign and date the *Waiver Agreement and FBI Privacy Act Statement* form with your application. Your application will not be deemed as completed without a completed and signed *Waiver Agreement and Statement* form.

Fingerprinting should be conducted by a person who is appropriately trained to collect fingerprints. Your local law enforcement agency should be willing to assist you with completing the fingerprints. Some enforcement agencies offer electronic scanning (Livescan). Please visit our website at http://www.ksbha.org/departments/licensing/licensingdept.shtml for a listing of Livescan agencies. Have at least one form of picture identification for the law enforcement agency to examine.

If you do not utilize a Livescan agency, contact the Board at 785 296-7413 or 888-886-7205 to receive a fingerprint card or visit https://www.fbi.gov/file-repository/standard-fingerprint-form-fd-258-1.pdf/view to print a fingerprint card. If printing the card please print on card stock paper.

Please complete the applicant section of the fingerprint card. Ensure the appropriate data fields are completed prior to submitting the fingerprint card. Be sure to include name (including aliases, maiden and previous names), complete mailing address, social security number, citizenship, date of birth, and personal information (sex, race, height, weight, eyes, hair, place of birth). The spaces for OCA, FBI and MNU numbers can be left blank. Cards with missing or incomplete information will be rejected and must be resubmitted. Sign the card in front of the law enforcement officer. If you use Livescan, the agency may have a different form for you to complete.

Make a check or money order (do not send cash) payable to the Kansas State Board of Healing Arts for **$47**. A fingerprint card submitted without payment will not be processed.

Provide the law enforcement officer with a stamped envelope addressed to KSBHA 800 Jackson LL-Suite A., Topeka KS 66612 to mail your fingerprint card or electronic scan, and fee. In addition, you may want to use a mailing service that allows for delivery confirmation to confirm your fingerprint card and payment have been received at the Board. Bent and folded cards will not be accepted and a new fingerprint card will be mailed to you for prints to be taken again.

A background check is valid for six (6) months. Application for licensure completed after the six (6) month period will be required to submit a new fingerprint card for a new clearance.

Any and all resubmissions of fingerprints cards require a $47 as of February 1, 2015 to process. Resubmitted fingerprint cards will not be processed without payment.

Please complete, sign and return the *Waiver Agreement and FBI Privacy Act Statement* form with your application. Your application will not be deemed as complete without a completed and signed *Waiver Agreement and FBI Privacy Act Statement* form.

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize (*Name of Authorized Recipient*) the Kansas State Board of Healing Arts to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. Pursuant to K.S.A. 22-4701 et seq. and K.S.A. 22-5001, the Authorized Recipient may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the above-referenced Authorized Recipient of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Authorized Recipient may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities until the criminal history background check is completed.

I understand that, upon my request, the Authorized Recipient will provide me a copy of the criminal history background report, received on me, for the purpose to challenge the accuracy and completeness of any information contained in any such report. I may be afforded a reasonable amount of time to correct or complete the criminal history record (or decline to do so) before the Authorized Recipient makes a final decision about my status as an employee, volunteer or contractor, or my eligibility for any pertinent license, certification or registration, or adoption. See 28 CFR 50.12(b).

I understand that officials receiving the results of the criminal history record check are to use those results only for authorized purposes and are prohibited from retaining or disseminating such results in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. (See 5 United States Code (USC) 552a(b); 28 USC 534(b); 42 USC 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), and 906.2(d).)

FBI PRIVACY ACT STATEMENT

Authority:
The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C.534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).
Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:
Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies)

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

Routine Uses:
The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:
The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

You may request a copy of your state and/or national criminal history record from the Authorized Recipient for the purpose of challenging for accuracy and completeness.

Alternatively, you may obtain a copy of your **Kansas criminal history record information** (CHRI) to review for accuracy and completeness, by submitting a set of your fingerprints, a letter requesting your criminal history record, and payment of the appropriate fee to the KBI. For further details, including the current fee, visit the following Internet website: http://www.kansas.gov/kbi/info/info_brochures.shtml then find the brochure named "Record Checks for Non-Criminal Justice Purposes". Or, to provide official court documents to make a correction you may write to:

Kansas Bureau of Investigation
Attn: Criminal History Records
1620 SW Tyler
Topeka, Kansas 66612-1837

If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license, certification or registration, or adoption.

To obtain a copy of your **national CHRI, also known as the Identity History Summary**, for review and challenge you must submit a set of your fingerprints and the appropriate fee to the FBI. Information regarding this process may be obtained at: https://www.fbi.gov/services/cjis/identity-history-summary-checks. Or, you may write to:

FBI CJIS Division
Attn: Criminal History Analysis Team 1
1000 Custer Hollow Road
Clarksburg, West Virginia 26306

ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

Select the discipline applying for and the license designation being requested.

☑ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

☐ Active	A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.
☐ Federal Active	A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.
☐ Inactive	A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.
☐ Exempt	A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

List intended professional activities: _____

Additional Information and Statement of Health:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☑ No
2. Give location of intended practice in Kansas Trust Women 5107 E. Kellogg Dr. Wichita, KS 67218.
3. Primary Specialty Obstetrics & Gynecology

   American Board Certified no American Board Eligible yes
4. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your particular branch of the healing arts or your particular specialty? CONFIDENTIAL

   If yes, applicant shall file with this application a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

From: Lizeth Lucio
To: Brown, Tammy [BOHA]
Cc: Geetha Fink; Julie Burkhart
Subject: Malpractice
Date: Friday, March 29, 2019 11:48:51 AM
Attachments: image001.png
86649912_AG.PDF
Kansas Quotes for Fink.pdf

CONFIDENTIAL

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TRUST WOMEN

[redacted]

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY
ON BEHALF OF KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN
TOPEKA, KANSAS

Premium Statement

FOR THE POLICY PERIOD 04/01/2019 TO 04/01/2020

Named Insured	Class	Premium	HCSF	Total
Geetha N. Fink, MD	[redacted]			

03/28/2019

QKSP27843-01

AGENT COPY

From: LaJeune Fitzpatrick
To: Lizeth Lucio
Cc: Molly Oakley
Subject: Kansas Quotes for Fink and GUH
Date: Friday, March 29, 2019 10:04:41 AM
Attachments: image001.png
86649912_AG.PDF
Importance: High

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