R - Full

Common License Application Form - Self-Reported

CC Pymt $300 1/17/08

TAP Username: tfranklin Submitted on: 1/11/2008 1:30 PM

1. Name

Name Tanya Ellis Franklin MD

Maiden Name Ellis

Alternate Name(s) Tanya Kay Ellis
Tanya Kay Franklin

2. Address/Phone

(Practice) 550 S. Jackson St.
Dept of Obstetrics and Gynecology
Louisville, KY 40202
USA
Public Access: Y
Mailing: N

(Home) [redacted]
Public Access: N
Mailing: Y

Phone

Business 502-561-2777
502-295-0891

Business Fax

Home [redacted]

Home Fax

Email

Primary [redacted]

Secondary [redacted]

3. Identification

Birth Date [redacted]

Location: [redacted]

[redacted]

SSN [redacted]

National Provider ID

U.S. Citizen Y

Gender [redacted]

4. Medical Education

School University of Louisville School of Medicine

Address 01602
Health Sciences Center
Louisville, KY 40292
USA

Attendance Dates 08/1999 to 05/2004

Grad Date 5/14/2004

Degree MSMD

5. Fifth Pathway

No information reported.

6. Postgraduate Medical Education

University of Louisville Hospital

Hospital University of Louisville Hospital
550 S. Jackson St.
Louisville 40202
USA

PGY

Year(s): PGY 1 **Internship/Residency**: Complete?: Completed
Obstetrics and Gynecology
Dates: 07/2004 to 06/2005

Year(s): PGY 2 **Residency**: Complete?: Completed
Obstetrics and Gynecology
Dates: 07/2005 to 06/2006

Year(s): PGY 3 **Residency**: Complete?: Completed
Obstetrics and Gynecology
Dates: 07/2006 to 06/2007

Year(s): PGY 4 **Residency**: Complete?: In Process
Obstetrics and Gynecology
Dates: 07/2007 to 06/2008

University of Louisville Hospital

Hospital University of Louisville Hospital
550 S. Jackson St.
Louisville 40202
USA

PGY

Year(s): PGY 1 **Internship/Residency**: Complete?: Completed
Obstetrics and Gynecology
Dates: 07/2004 to 06/2005

7. Examination History

Exam	USMLE3
Date	12/2004
Attempts	1
Pass/Fail	P
Exam	USMLE1
Date	
Attempts	1
Pass/Fail	P
Exam	USMLE2
Date	
Attempts	1
Pass/Fail	P

8. ECFMG

ECFMG ID:
Cert Date:

9. State or Professional Licensure

State	KY
License Number	R0980
Type	MD: Doctor of Medicine
Status	ACT

Issue Date 7/1/2007

10. Chronology of Activities

Dates	07/2004 to In Progress
Practice/Employment Name	University of Louisville
Address	550 S. Jackson St Louisville, KY 40202
Position	Resident
Department	OB GYN
% Clinical / % Adm	0% / 0%
Employment	N
Staff Priviledges	N
Affiliation	N
Other	N

11. Malpractice Liability Claims Information

No information reported.

TAP Username: tfranklin Submission tracking ID: 7005 **Self-Reported**

AMS ADVANTAGE

Personalize Home Help Logout

Welcome: Noyes, Rachel Application Administration Payment Processing

Process Payment

Find and Maintain Transactions

Transaction Summary

Your payment has been successfully processed. Please use the following information when referencing this transaction:

Merchant : Kentucky Board of Medical Licensure (KY245-KBML)
ePay transaction number : 3755229
Order number : Franklin
MSP transaction number : 22165509
Authorization code : 083226
Transaction date : 2008-01-17 03:10 PM

Print This Page View Transaction Details Process Another Payment

Payment Info

Payment Items :	Description	Smart Code	Amount ($)
	Application Fee	PHYNEW	300.00
		Total amount :	300.00

Comments :

Billing Info

Name : Ob/GYN & Women's Health
eMail Address : [redacted]
Phone number :
Address :

Payment Method

Credit Card (Charge) Info

Card number (last five digits) : [redacted]
Card verification value :
Expiration date : [redacted]

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

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

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

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

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

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

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

Tanya Franklin
Applicant's Signature (must be signed in the presence of a notary)

Franklin
Applicant's Printed Last Name

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

1/11/08
Date of Signature

NOTARY

Dated 1/11/08 Signed Vicki D. Masterson

State of Kentucky County of Jefferson

SUBSCRIBED AND SWORN TO before me this 11TH day of January 2008.

My commission expires: 4/19/2009 (NOTARY PUBLIC SIGNATURE & SEAL)

Addendum 1
[Category I]

Please answer all questions on this application. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification. If you answer "Yes" to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer "yes" in such circumstance even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license. This application may not be altered in any way.

1. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence, or been placed on probation or reprimanded at a medical school or a postgraduate training program?
   ☐Yes ☒No
2. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
   ☐Yes ☒No
3. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
   ☐Yes ☒No
4. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?
   ☐Yes ☒No
5. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
   ☐Yes ☒No
6. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
   ☐Yes ☒No
7. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
   ☐Yes ☒No
8. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
   ☐Yes ☒No
9. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
   ☐Yes ☒No

10. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☒No

11. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☒No

12. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court?
☐Yes ☒No

13. Are any criminal charges presently pending against you in any of those courts?
☐Yes ☒No

14. To your knowledge, are you the subject of an investigation for a criminal act?
☐Yes ☒No

15. In the past ten (10) years have you had to pay a judgment in a malpractice action or other civil action against your medical practice or are any malpractice or other civil actions against your medical practice presently pending in any court? **(If yes, complete the Malpractice Liability Claims Information, page 10, Section 11 of the CLA-F.)**
☐Yes ☒No

16. Have you ever applied for or been issued a Kentucky medical license? ☒Yes ☐No If yes, # R0980

17. Are you currently certified by an American Specialty Board? ☐Yes ☒No

If yes, by what Board? _____

18. List the Specialty that you will be practicing in KY and specify type of practice (Check only one type of practice):

Specialty: Generalist - Ob/gyn

☐Hospital Base	☐Occupational Medicine	☒Instructor	☐Military
☐Admin. Medicine	☐Research	☐Resident/Fellow	☐Emergency Medicine
☐Private Practice	☐Inactive/Semi-Retired	☐Locum Tenens	☐Teleradiology

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

Tanya Franklin 1/11/08

(Signature of Applicant signed in presence of Notary) **(Date)**

Tanya Franklin

(Print Name)

Subscribed and sworn to before me by the above named applicant on this 11TH day of 1 | 08
(Month, Year)

Vicki J Masterson

(Signature of Notary)

My commission expires: 4/9/2009

Seal of Notary

"Only the applicant and person authorized by applicant may call regarding the credentialing of your application or be given information during the credentialing process."
Specify name of authorized person: Vicki Masterson

Addendum 2
[Category II]

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (I) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.
"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
[redacted]
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
[redacted]
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
[redacted]
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
[redacted]
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
[redacted]

See above exemption

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

[redacted] 11/11/08

(Signature of Applicant signed in presence of Notary) **(Date)**

Franklin, Tanya Ellis

(Print Name)

Subscribed and sworn to before me by the above named applicant on this 11TH day of 11/08
(Month, Year)

Seal of Notary [redacted]

(Signature of Notary)

My commission expires: 4/19/2009

Addendum 4

Physicians Name Franklin, Tanya Ellis M.D. / D.O.

List all hospitals, clinic, etc., other than training where you have practiced medicine within the last five (5) years and send Addendum 4A to each. If you have more than 20 affiliations in the past 5 years, you will only be required to verify the last 20 affiliations. *(This should include moonlighting, administrative and all locum tenens assignments.)*

Dates (From – To)	Hospitals/Clinic/Office Name	Complete Address	Indicate Locum Tenens, Moonlighting or Type of Privileges
No other hospitals besides training			

CME Form

Name Franklin, Tanya Ellis
(Please Print or Type)

Record of Category I Continuing Medical Education Credits(Last 3 years)
DO NOT PROVIDE DOCUMENTATION

Dates:	Name of Activity/Course	# of Credit Hours
As a	resident - Cannot get CME's.	
	N/A	

I attest that the above is valid.

Signature

1/11/08
Date

Success

The following email message was sent.

To: [redacted]
Subject: AIDS Course Certificate
U OF L Continuing Health Sciences Education
Online "HIV/AIDS" Update Course Certificate
++
This document certifies that the individual listed below has successfully completed the University of Louisville Continuing Health Sciences Education's "HIV/AIDS Update" Online Course. The completion of this course fulfills the requirements of Kentucky Regulatory Statute (KRS) 214.610/615. The course's Kentucky Cabinet for Health Services (CHS) approval number is 1005-1526-M.

If the participant is a physician, they have earned two hours of Category 1 credit towards the American Medical Association's (AMA) Physician's Recognition Award.

If the participant is a nurse, they have earned 2.5 contact hours of continuing education credit. This program has been approved by the Kentucky Board of Nursing fo 2.5 contact hours through the University of Louisville School of Nursing, provider number 3-0046-7-05-024.

PLEASE PRINT THIS DOCUMENT AND KEEP IT ON FILE FOR PURPOSES OF AUDIT, OR FILE IT WITH YOUR LICENSURE BOARD IF REQUIRED. IT WILL NOT BE E-MAILED TO YOU UNLESS YOU SPECIFICALLY REQUEST THIS SERVICE BY CONTACTING US AT chse@louisville.edu.

Please direct any questions to U of L Continuing Health Sciences Education at chse@louisville.edu or 502-852-5329.

First Name: Tanya
Middle Initial: E
Last Name: Franklin

Social Security Number: [redacted]
Date: April 6, 2004
UofL Resident or Incoming Resident: Yes
++

cgiemail 1.6

RECEIVED
JAN 17 2008
K.B.M.L.

Addendum 4A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application. If you have more than 20 affiliations in the past 5 years, you will only be required to verify the last 20 affiliations. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name: Franklin, Tanya Ellis (M.D./D.O.) TFranklin MD
(Please print) (Signature)

Name and Address of Facility: University Of Louisville Hosp 550 S. JACKSON ST Louisville KY 40202

****

To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. Position and Department of the above applicant? OBGYN Resident
2. Affiliation Dates: From July 1, 2004 To NOW (present)
3. Were any limitations imposed on this physician? NO If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action.
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? NO If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action.
5. Was the above physician terminated from employment? NO If yes, please explain in detail.

Derogatory Information, if any:

Comments, if any:

Professor & Chair; Residency Program Director

Signature, Date, Title C L Cook MD 1/14/08

Printed Name Christine L. Cook, MD

Facility University of Louisville

Address Dept. of OB/GYN & Women's Health
Louisville, KY 40292

Phone Number (502) 561-7441

Affix Seal Here
(If no seal, so indicate)
No Seal

Addendum 5 – Reference Form

Kentucky Board of Medical Licensure
310 Whittington Pkwy., #1B
Louisville, KY 40222
www.kbml.ky.gov

RECEIVED
MAR - 6 2008
K.B.M.L.

This form is to be completed by a physician fully licensed in the state which the form is notarized. The recommending physician must have known the applicant for at least six months. Relatives may not serve as recommending physicians nor may physicians who are currently in the process of applying for a KY license. Recommending physicians are strongly urged to include additional comments. The recommending physician must have this form notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return to the Kentucky Board of Medical Licensure at the address above.

Do not complete unless a color photo of applicant is attached to the bottom of this form.
Black and white photos are not accepted.

I, RITA A. FLEMING, a licensed and practicing physician in the state of KENTUCKY
(recommending physician, print name legibly) (state of practice)

affirm that Tanya Franklin has been known to me personally for 3 years
(applicant, print name legibly)

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for Kentucky licensure:

- I rate his/her medical knowledge and technique as: excellent
- His/her relationship with patients is: excellent
- I rate his/her ability to work well with peers and medical staff as: excellent
- His/her command of the English language is: excellent
- Additional comments: _____

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the state of Kentucky.

Printed Name and Signature of Recommending Physician (name stamps will not be accepted)	RITA. A. FLEMING Rita A. Fleming
State of Licensure and License Number	KY. 24679

Address of Recommending Physician	550 SO. JACKSON ST	LOUISVILLE KY 40202	502-561-7462
	Street Address	City, State, Zip	Phone (include area code)

Subscribed and sworn to before me this 3RD day of March, 20 08.

Notary Public Signature

Date Commission Expires 4/19/2009

Signature of Applicant Franklin 2/8/08 Date Photo Taken 10/1/07

Printed Name of Applicant Franklin, Tanya Ellis

AMA AMERICAN MEDICAL ASSOCIATION

RECEIVED
MAR - 6 2008
K.B.M.L.

AMA Physician Profile

Name and Mailing Address:

(Franklin)
TANYA KAY ELLIS MD
UL GME OFFICE RM518
323 E CHESTNUT ST
LOUISVILLE KY 40202-1823

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: UNKNOWN

Birthdate: [redacted]
Birthplace:

Physician's Major Professional Activity: HOSPITAL BASED RESIDENTS - ALL YEARS

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (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, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

UNIV OF LOUISVILLE SCH OF MED, LOUISVILLE KY 40202

Degree Awarded: Yes

Degree Year: 2004

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association ("AMA") and the Requesting Organization that the physician profiles being requested are provided to the Requesting Organization with the understanding that: (1) the information on the physician profiles will be treated with complete confidentiality; (2) such information is granted solely to the Requesting Organization and is granted as a non-exclusive limited license, consistent with and limited to the sole and specific purpose of verifying physicians' credentials; (3) no physician profile information will be released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency; (4) no physician profile obtained or any information contained therein will be used as a vehicle to create, maintain or enhance another database; and (5) that upon breach of any of the foregoing covenants this license to use and possess physician profiles shall be automatically and immediately terminated and no further physician profiles shall be provided by AMA.

AMA endeavors to maintain its physician profiles with information that is accurate, complete and current; however, because AMA compiles data from numerous and varied sources, and therefore may experience reporting and processing errors or delays, no representations or warranties as to the accuracy or completeness of the data or as to the uninterrupted access can be or are made.

AMA makes no representations or warranties of any nature, with respect to the physician profiles obtained including without limitation, the implied warranties of merchantability and fitness for any particular purpose, nor assumes any responsibility or legal liability for Requesting Organization's use or the results of its use of such profiles. In consideration of the receipt of each physician profile provided by AMA, the Requesting Organization hereby releases AMA and their respective agents and servants from any and all liability whatsoever for inaccurate or incomplete information in any physician profile obtained.

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: UNIV LOUISVILLE SCH OF MED — **State:** KENTUCKY
Specialty : OBSTETRICS & GYNECOLOGY — 07/2004 - 06/2008 (VERIFIED)

Note: **If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.**

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
KENTUCKY	MD	07/01/2005	06/30/2008	ACTIVE	RESIDENT	12/04/2007

Note: **When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.**

ECFMG Certfication:

Applicant Number:

Note: **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 in writing at P.O. Box 13679, Philadelphia, PA 19101.**

Federal Drug Enforcement Administration:

** Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
None	Reported		

Note: **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.**

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association ("AMA") and the Requesting Organization that the physician profiles being requested are provided to the Requesting Organization with the understanding that: (1) the information on the physician profiles will be treated with complete confidentiality; (2) such information is granted solely to the Requesting Organization and is granted as a non-exclusive limited license, consistent with and limited to the sole and specific purpose of verifying physicians' credentials; (3) no physician profile information will be released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency; (4) no physician profile obtained or any information contained therein will be used as a vehicle to create, maintain or enhance another database; and (5) that upon breach of any of the foregoing covenants this license to use and possess physician profiles shall be automatically and immediately terminated and no further physician profiles shall be provided by AMA.

AMA endeavors to maintain its physician profiles with information that is accurate, complete and current; however, because AMA compiles data from numerous and varied sources, and therefore may experience reporting and processing errors or delays, no representations or warranties as to the accuracy or completeness of the data or as to the uninterrupted access can be or are made.

AMA makes no representations or warranties of any nature, with respect to the physician profiles obtained including without limitation, the implied warranties of merchantability and fitness for any particular purpose, nor assumes any responsibility or legal liability for Requesting Organization's use or the results of its use of such profiles. In consideration of the receipt of each physician profile provided by AMA, the Requesting Organization hereby releases AMA and their respective agents and servants from any and all liability whatsoever for inaccurate or incomplete information in any physician profile obtained.

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Specialty Board Certification(s)*:

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 accrediting bodies such as the Joint Commission and National Committee for Quality Assurance (NCQA).

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:

Duration	Effective	Expiration	Occurrence	Last Reported

Note: **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. (**) Indicates an expired certificate.**

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

It is mutually agreed between the American Medical Association ("AMA") and the Requesting Organization that the physician profiles being requested are provided to the Requesting Organization with the understanding that: (1) the information on the physician profiles will be treated with complete confidentiality; (2) such information is granted solely to the Requesting Organization and is granted as a non-exclusive limited license, consistent with and limited to the sole and specific purpose of verifying physicians' credentials; (3) no physician profile information will be released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency; (4) no physician profile obtained or any information contained therein will be used as a vehicle to create, maintain or enhance another database; and (5) that upon breach of any of the foregoing covenants this license to use and possess physician profiles shall be automatically and immediately terminated and no further physician profiles shall be provided by AMA.

AMA endeavors to maintain its physician profiles with information that is accurate, complete and current; however, because AMA compiles data from numerous and varied sources, and therefore may experience reporting and processing errors or delays, no representations or warranties as to the accuracy or completeness of the data or as to the uninterrupted access can be or are made.

AMA makes no representations or warranties of any nature, with respect to the physician profiles obtained including without limitation, the implied warranties of merchantability and fitness for any particular purpose, nor assumes any responsibility or legal liability for Requesting Organization's use or the results of its use of such profiles. In consideration of the receipt of each physician profile provided by AMA, the Requesting Organization hereby releases AMA and their respective agents and servants from any and all liability whatsoever for inaccurate or incomplete information in any physician profile obtained.

AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site (http://www.ama-assn.org/go/amaprofiles) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association ("AMA") and the Requesting Organization that the physician profiles being requested are provided to the Requesting Organization with the understanding that: (1) the information on the physician profiles will be treated with complete confidentiality; (2) such information is granted solely to the Requesting Organization and is granted as a non-exclusive limited license, consistent with and limited to the sole and specific purpose of verifying physicians' credentials; (3) no physician profile information will be released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency; (4) no physician profile obtained or any information contained therein will be used as a vehicle to create, maintain or enhance another database; and (5) that upon breach of any of the foregoing covenants this license to use and possess physician profiles shall be automatically and immediately terminated and no further physician profiles shall be provided by AMA.

AMA endeavors to maintain its physician profiles with information that is accurate, complete and current; however, because AMA compiles data from numerous and varied sources, and therefore may experience reporting and processing errors or delays, no representations or warranties as to the accuracy or completeness of the data or as to the uninterrupted access can be or are made.

AMA makes no representations or warranties of any nature, with respect to the physician profiles obtained including without limitation, the implied warranties of merchantability and fitness for any particular purpose, nor assumes any responsibility or legal liability for Requesting Organization's use or the results of its use of such profiles. In consideration of the receipt of each physician profile provided by AMA, the Requesting Organization hereby releases AMA and their respective agents and servants from any and all liability whatsoever for inaccurate or incomplete information in any physician profile obtained.

Addendum 5 – Reference Form

Kentucky Board of Medical Licensure
310 Whittington Pkwy., #1B
Louisville, KY 40222
www.kbml.ky.gov

RECEIVED
MAR - 4 2008
K.B.M.L.

This form is to be completed by a physician fully licensed in the state which the form is notarized. The recommending physician must have known the applicant for at least six months. Relatives may not serve as recommending physicians nor may physicians who are currently in the process of applying for a KY license. Recommending physicians are strongly urged to include additional comments. The recommending physician must have this form notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return to the Kentucky Board of Medical Licensure at the address above.

Do not complete unless a color photo of applicant is attached to the bottom of this form.
Black and white photos are not accepted.

I, Christine L. Cook, MD (recommending physician, print name legibly), a licensed and practicing physician in the state of Kentucky (state of practice)

affirm that Tanya Franklin, MD (applicant, print name legibly) has been known to me personally for 6 years

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for Kentucky licensure:

- I rate his/her medical knowledge and technique as: excellent
- His/her relationship with patients is: excellent
- I rate his/her ability to work well with peers and medical staff as: excellent
- His/her command of the English language is: excellent
- Additional comments: _____

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the state of Kentucky.

Printed Name and Signature of Recommending Physician (name stamps will not be accepted)	C L Cook MD Christine L. Cook, MD Professor & Chairman; Residency Program Director
State of Licensure and License Number	Kentucky 16317

Address of Recommending Physician	Dept. of OB/GYN 550 S. Jackson Street	Louisville, KY 40202	(502) 561-7441
et Address		City, State, Zip	Phone (include area code)

Subscribed and sworn to before me this 29TH day of February, 20 07.

Victoria Masterson
Notary Public Signature

Date Commission Expires 4/19/2009

Signature of Applicant [signature] 2/8/08 Date Photo Taken 10/1/07

Printed Name of Applicant Franklin, Tanya Ellis

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

RECEIVED
MAR 17 2008
KRML

DCN: 5500000050048758
Process Date: 03/07/2008

NPDB RESPONSE TO SELF-QUERY

A. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: FRANKLIN, TANYA ELLIS
Gender: [redacted]
Date of Birth: [redacted]
Other Name(s) Used:
Organization Name: UNIVERSITY OF LOUISVILLE
Organization Type: OTHER TYPE NOT CLASSIFIED - SPECIFY (999)
Other, as Specified: RESIDENT IN-TRAINING AT HOSPITAL
Home or Work Address: UNIVERSITY OF LOUISVILLE, DEPT. OF OBGYN
550 S. JACKSON STREET, 2ND FL, ACB BLDG.
City, State, ZIP: LOUISVILLE, KY 40202
Country:

Social Security Numbers (SSN): [redacted]
Individual Taxpayer Identification Numbers (ITIN):

Federal Employer Identification Numbers (FEIN):

National Provider Identifiers (NPI): 1114060621

Drug Enforcement Administration (DEA) Numbers: BF9376395

Unique Physician Identification Numbers (UPIN):

Professional School(s) & Year(s) of Graduation: UNIVERSITY OF LOUISVILLE SCHOOL OF MED 2004
UNIVERSITY OF LOUISVILLE - RESIDENCY 2008

Occupation/Field of Licensure (Code): PHYSICIAN INTERN/RESIDENT (MD) (015)
State License Numbers, State of Licensure: R0980, KY
Other, as Specified:
Specialty: OBSTETRICS & GYNECOLOGY (50)

Occupation/Field of Licensure (Code): PHYSICIAN INTERN/RESIDENT (MD) (015)
State License Numbers, State of Licensure: 11013556A, IN
Other, as Specified:
Specialty: OBSTETRICS & GYNECOLOGY (50)

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

B. PAYMENT INFORMATION

Payment Type: CREDIT CARD
Account Number: [redacted]
Expiration Date: [redacted]
Transaction Date: 03/07/2008
Transaction Number: [redacted]
Total Charge: $8.00

C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the NPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended. Recipients should verify that the subject identified in Section A of the report(s) is, in fact, the subject of interest. Information from the NPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 5500000050048758
Process Date: 03/07/2008

HIPDB RESPONSE TO SELF-QUERY

A. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: FRANKLIN, TANYA ELLIS
Gender: [redacted]
Date of Birth:
Other Name(s) Used:
Organization Name: UNIVERSITY OF LOUISVILLE
Organization Type: OTHER TYPE NOT CLASSIFIED - SPECIFY (999)
Other, as Specified: RESIDENT IN-TRAINING AT HOSPITAL
Home or Work Address: UNIVERSITY OF LOUISVILLE, DEPT. OF OBGYN
550 S. JACKSON STREET, 2ND FL, ACB BLDG.
City, State, ZIP: LOUISVILLE, KY 40202
Country:

Social Security Numbers (SSN): [redacted]
Individual Taxpayer Identification Numbers (ITIN):
Federal Employer Identification Numbers (FEIN):
National Provider Identifiers (NPI): 1114060621
Drug Enforcement Administration (DEA) Numbers: BF9376395
Unique Physician Identification Numbers (UPIN):

Professional School(s) & Year(s) of Graduation: UNIVERSITY OF LOUISVILLE SCHOOL OF MED 2004
UNIVERSITY OF LOUISVILLE - RESIDENCY 2008
Occupation/Field of Licensure (Code): PHYSICIAN INTERN/RESIDENT (MD) (015)
State License Numbers, State of Licensure: R0980, KY
Other, as Specified:
Specialty: OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code): PHYSICIAN INTERN/RESIDENT (MD) (015)
State License Numbers, State of Licensure: 11013556A, IN
Other, as Specified:
Specialty: OBSTETRICS & GYNECOLOGY (50)

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

B. PAYMENT INFORMATION

Payment Type: CREDIT CARD
Account Number: [redacted]
Expiration Date:
Transaction Date: 03/07/2008
Transaction Number: [redacted]
Total Charge: $8.00

C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the HIPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Section 1128E of the Social Security Act. Recipients should verify that the subject identified in Section A of the report(s) is, in fact, the subject of interest. Information from the HIPDB is confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Tanya Ellis Franklin**
SSN:	[redacted]
DOB:	
Packet ID:	**84903**
Recipient:	**Kentucky Board of Medical Licensure**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician 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. All documents bearing the official FCVS seal are ceritified 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.

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FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Tanya Ellis Franklin**	
Other Name Used:	**Tanya Kay Ellis**	
	Tanya Kay Franklin	
Gender:	[redacted]	
Date of Birth:		
Place of Birth:		
SSN:		
Current Address:	[redacted]	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**502-561-2777**
	Fax:	**502-561-2405**
	Home:	[redacted]
	Other:	
Physical Description:	Height:	**5' 05"**
	Weight:	**160 lbs**
	Eye Color:	**Brown**
	Hair Color:	**Black**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**Bellarmine College, Louisville, KY 40205**
Dates of Attendance:	**08/1995 - 05/1999**
Degree Conferred/Issued:	**Bachelor of Arts**

Medical Education:

Medical School:	**University of Louisville School of Medicine** **323 East Chestnut Street** **404 Abell Administration Center** **Louisville, KY 40202-3866**
Dates of Attendance:	**08/16/1999 - 04/30/2004**
Date Degree Conferred/Issued:	**05/08/2004**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**Leave** **See Form**

Post Graduate Medical Education:

Institution:	**University of Louisville** **Department of Obstetrics and Gynecology** **550 South Jackson Street** **Louisville, KY 40292**
Post Graduate Year:	**1**
Program Type:	**Internship**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2004 - 06/30/2005**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**2-3**
Program Type:	**Residency**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2005 - 06/30/2007**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**4**
Program Type:	**Residency**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2007 - 06/30/2008**
Completion:	**To Be Completed On 06/30/2008**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

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

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Tanya Ellis Franklin
DOB:	
SSN:	[redacted]
Packet ID:	84903
Request ID:	18707161

OMISSIONS

There are none identified.

DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant responded No to all of the questions in the Unusual Circumstances Section of the application for attendance at U Louisville Sch Med. The institution responded Yes to the Leave question(s) in the Unusual Circumstances Section of the Verification of Medical Education form.
Follow-Up:	See comments on Verification of Medical Education Form. A copy of the FCVS Medical Education application page completed by the applicant is included.

Discrepancy 2:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant reports the degree/diploma was issued/conferred/awarded by U Louisville Sch Med on 05/14/2004. The institution reports 05/08/2004.
Follow-Up:	FCVS reports the date the degree/diploma was issued/conferred/awarded from the medical school diploma on the Physician Information Report.

Discrepancy 3:

Section of Profile:	**Examination History**
Discrepancy:	The applicant reports sitting for USMLE Step 2 as `Date Unknown`. The USMLE transcript reports the examination date was 06/12/2003, respectively.
Follow-Up:	Left to Recipient's discretion.

MISCELLANEOUS INFORMATION

There are none identified.

End of report for Tanya Ellis Franklin

Packet Id: 84903 Request Id: 18707161 Report Created By: TEMP1

Board Action Databank Search

State Queried For:	**Kentucky Board of Medical Licensure**
Physician's Name	**Franklin, Tanya Ellis**
Date of Birth:	[redacted]
Medical School:	**018020 - University of Louisville School of Medicine**
Year of Graduation:	**2004**
Social Security Number:	[redacted]
ECFMG Number:	**N/A**

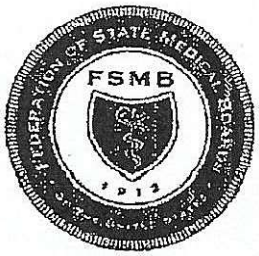
Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

APR 24 2008

James N. Thompson

JAMES N. THOMPSON, MD
PRESIDENT AND CHIEF EXECUTIVE OFFICER



AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 4/24/2008

State Queried For: Kentucky Board of Medical Licensure

Physician Name: Tanya Ellis Franklin

Date of Birth:

Year of Graduation:

Social Security Number:

ABMSU ID:

The data provided to FCVS by the ABMS does not include Specialty Certification information on file for this physician. This does not mean that the physician is not certified by one or more of the Member Boards of the American Board of Medical Specialties, as the data provided by ABMS does not include some physicians for which they have incomplete data.

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

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

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" 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 waive confidentiality, 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 (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, 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 FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

Tanya Franklin

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

Franklin

Applicant's Printed Last Name

Tanya E.

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

3/6/08

Date of [redacted]

[redacted]

Date of Birth

Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of Kentucky County of Jefferson

SUBSCRIBED AND SWORN TO before me this 6th day of March, 20 08

My commission expires: 4/19/2009

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: Debra J Masters

I certify that on the date set forth above 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.

CERTIFICATION OF VITAL RECORD

DEPARTMENT OF STATE HEALTH SERVICES
VITAL STATISTICS UNIT

[redacted] DEPARTMENT OF HEALTH RESOURCES
RECD [redacted]
BUREAU OF VITAL STATISTICS

178-01-2 178-01

CERTIFICATE OF BIRTH BIRTH NO. [redacted]

STATE OF TEXAS

Texas Department of Health Resources — BUREAU OF VITAL STATISTICS

1. PLACE OF BIRTH
a. COUNTY [redacted]
b. CITY OR TOWN [redacted]
c. NAME OF HOSPITAL OR INSTITUTION [redacted]
d. IS PLACE OF BIRTH INSIDE CITY LIMITS? YES [redacted] NO [redacted]

2. USUAL RESIDENCE OF MOTHER [Where does mother live?]
a. STATE [redacted] b. COUNTY [redacted]
outside city limits, give precinct [redacted] ZIP CODE [redacted]
d. STREET OR RURAL ROUTE [redacted]
e. IS RESIDENCE INSIDE CITY LIMITS? YES [redacted] NO [redacted]
f. IS RESIDENCE ON A FARM? YES [redacted] NO [redacted]

CHILD
3. NAME [Type or Print] [a] First: Tanya [b] Middle: Kay [c] Last: Ellis
4. DATE OF BIRTH [redacted]
5. SEX [redacted]
6a. THIS BIRTH SINGLE [redacted] TWIN [redacted] TRIPLE [redacted]
6b. IF TWIN OR TRIPLET, WAS CHILD BORN 1st [redacted] 2nd 3rd [redacted]

FATHER
7. NAME [a] First [redacted] [b] Middle [redacted] [c] Last [redacted]
8. COLOR OR RACE [redacted]
9. AGE [At time of this birth] [redacted] YEARS
10. BIRTHPLACE [State or foreign country] [redacted]
11a. USUAL OCCUPATION [redacted]
11b. KIND OF BUSINESS OR INDUSTRY [redacted]

MOTHER
12. MAIDEN NAME [a] First [redacted] [b] Middle [redacted] [c] Last [redacted]
13. COLOR OR RACE [redacted]
14. AGE [At time of this birth] [redacted] YEARS
15. BIRTHPLACE [State or foreign country] [redacted]
16. CHILDREN PREVIOUSLY BORN TO THIS MOTHER [Do NOT include this child]
a. How many OTHER children are now living? [redacted]
b. How many OTHER children were born alive but are now dead? [redacted]
c. How many children were born dead [fetal deaths after 20 weeks pregnancy]? [redacted]

17. [redacted]

18. I hereby certify that this child was born alive on the date stated above
at 3:28 a.m.
19a. ATTENDANT'S SIGNATURE A. Carreno
19b. ATTENDANT AT BIRTH M.D. ☒ D.O. ☐ MIDWIFE ☐ OTHER ☐
19c. ATTENDANT'S ADDRESS [redacted]
19d. DATE SIGNED [redacted]
20a. REGISTRAR'S FILE NO. 1196
20b. DATE REC'D BY LOCAL REGISTRAR [redacted]
20c. REGISTRAR'S SIGNATURE G. R. Metzger, M.D.

K0088320

SEAL VERIFIED

This is a true and correct reproduction of the original record as recorded in this office. Issued under authority of Section 191.051, Health and Safety Code.

ISSUED MAR 04 2008

Geraldine R. Harris
GERALDINE R. HARRIS
STATE REGISTRAR

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

[redacted]

Certificate of Marriage

This certifies that on the [redacted] day of [redacted], [redacted], Age [redacted]

and [redacted], Age [redacted]

obtained from the [redacted]

a License to Marry, and they were Married by

[redacted] at [redacted] on the

[redacted] day of [redacted], in the presence of

[redacted] and [redacted]

The above appears in Marriage Book No. [redacted], Page [redacted], on file in the office of the [redacted] County of Jefferson:

I, Bobbie Holsclaw, Clerk of the county and state aforesaid do hereby certify the above and foregoing to be true and accurate record of the Marriage License as recorded in Book [redacted], Page [redacted] in my office at [redacted]

Given under my hand this [redacted].

Bobbie Holsclaw County Clerk

F[redacted]ATION CREDENTIALS VERIFICATION SERVI[redacted]CVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

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 complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

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).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Louisville School of Medicine

Complete Address:

Street Address:

STUDENT AFFAIRS OFFICE
UNIVERSITY OF LOUISVILLE
ABELL ADMINISTRATION CENTER
~~323 E. CHESTNUT ST.~~
LOUISVILLE, KY 40202-3866

City: _____ **State:** _____ **ZIP Code (Postal Code):** _____

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

_____

Premedical Education:

Years of education required for admission to your medical school: 3+years

Credential/degree presented by the applicant for admission to your medical school: Bachelor's

Enrollment and Participation: Our records indicate that Franklin, Tanya Ellis
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 192 weeks of medical education on the following dates (mm/dd/yy):

From 8 (Month) , 16 (Date) , 99 (Year) **To** 4 (Month) , 30 (Date) , 04 (Year)

This individual (check one):

Was awarded the degree of Doctor of Medicine on 5 (Month) , 8 (Date) , 04 (Year)

Was NOT awarded a degree because: _____
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Sherri Gary (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

SEAL VERIFIED

Affix Institutional Seal Here. If no seal is available, this form must be notarized.

Signature: Sherri Gary

Title: Sr. Academic Coordinator

Date of Signature: 3/31/08

Phone: 502 852-5412 **Fax:** 502 852-0352

Email:

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☑ NO ☐

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)	6/02	5/04	☑	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

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

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

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify 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? Response YES ☐ 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 or an investigation by the medical school or parent university? Response YES ☐ 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? Response YES ☐ NO ☑

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