Uniform Application for Licensure

Application ID: 273088
FID: 215839259

License Requested: MD
License Type: Permanent Medical License
Submitted to: Kansas State Board of Healing Arts
Submission Date: 02/26/2019

Practitioner Name

Guh, Jessica Wendy

Alternate Name(s): Guh, Jessica

Contact Information

Address

Public Access	Board Contact	Type	Address
No	No	Home	[redacted] UNITED STATES
Yes	Yes	Business	Trust Women Foundation 5107 E Kellogg Dr WICHITA WICHITA, KS 67218 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	Yes	Business	(617) 460-0165	
No	No	Mobile	[redacted]	

Email

Public Access	Board Contact	Email
No	No	[redacted]
No	No	[redacted]
No	No	[redacted]
Yes	Yes	admin@southwindwomenscenter.org

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
52375573	[redacted]	[redacted]	New London, CT UNITED STATES	F	1851652135	MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
University of Michigan Medical School	1301 Catherine Road Ann Arbor, MI 481090624 UNITED STATES	08/04/2008	05/11/2012	05/11/2012	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name: **Swedish Medical Center/Cherry Hill Program**
Seattle, WA UNITED STATES

Program Code: ACGME 1205421328

Attendance Dates:

Institution: Swedish Medical Center

Start Date: 06/25/2012

Training Specialty: Family Medicine

End Date: 06/24/2013

Program Type: Internship

Training Status: Completed

Clinical %: 85

Administrative %: 15

Hospital Name: **Swedish Medical Center/Cherry Hill Program**
Seattle, WA UNITED STATES

Program Code: ACGME 1205421328

Attendance Dates:

Institution: Swedish Medical Center

Start Date: 06/25/2013

Training Specialty: Family Medicine

End Date: 06/24/2014

Program Type: Residency

Training Status: Completed

Clinical %: 85

Administrative %: 15

Hospital Name: **Swedish Medical Center/Cherry Hill Program**
Seattle, WA UNITED STATES

Program Code: ACGME 1205421328

Attendance Dates:

Institution: Swedish Medical Center

Start Date: 06/25/2014

Training Specialty: Family Medicine

End Date: 07/24/2015

Program Type: Residency

Training Status: Completed

Clinical %: 85

Administrative %: 15

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		04/26/2010	Pass	1
USMLE Step 2 CK Examination		08/03/2011	Pass	1
USMLE Step 2 CS Examination		10/05/2011	Pass	1
USMLE Step 3 Examination		02/03/2014	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Washington Medical Quality Assurance Commission	WA	MD60467205	06/20/2014	09/14/2019	Full	Active
Washington Medical Quality Assurance Commission	WA	ML60288612	05/30/2012	06/20/2014	Training	Expired
Texas Medical Board	TX	Q8496	06/01/2016	08/31/2020	Full	Active

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: **University of Michigan Medical School**
Chronology Type: Medical Education
Address: Ann Arbor, MI US
Attendance Dates:
Position/Dept:
Start Date: 08/04/2008
End Date: 05/11/2012
Clinical %:
Admin %:
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **Swedish Medical Center/Cherry Hill Program**
Chronology Type: Accredited Training
Address: Seattle, WA US
Attendance Dates:
Position/Dept:
Start Date: 06/25/2012
End Date: 06/24/2013
Clinical %: 85
Admin %: 15
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **Swedish Medical Center/Cherry Hill Program**
Chronology Type: Accredited Training
Address: Seattle, WA US
Attendance Dates:
Position/Dept:
Start Date: 06/25/2013
End Date: 06/24/2014
Clinical %: 85
Admin %: 15
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: **Swedish Medical Center/Cherry Hill Program**
Chronology Type: Accredited Training

Address: Seattle, WA
US

Attendance Dates:

Position/Dept:

Start Date: 06/25/2014

End Date: 07/24/2015

Clinical %: 85

Admin %: 15

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

Practice/Emp/ Desc: **International Community Health Services**

Chronology Type: Work

Address: 3815 S. Thello 2nd Fl
Seattle, WA 98118
US

Attendance Dates:

Position/Dept: Physician/Residency site Director - Family Medicine

Start Date: 07/01/2015

End Date: In Progress

Clinical %: 60

Admin %: 40

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

Practice/Emp/ Desc: **SouthWestern Women's Surgery Center**

Chronology Type: Work

Address: 8616 Greenville AVE 101
Dallas, TX 75243
US

Attendance Dates:

Position/Dept: Physcian - Medical Staff (MD)

Start Date: 06/01/2016

End Date: In Progress

Clinical %: 100

Admin %: 0

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

Malpractice

None Reported

FCVS

FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Guh, Jessica Wendy**
Social Security Number:	[redacted]
Date of Birth:	[redacted]
FID#:	**215839259**
Recipient:	**KS - Kansas State Board of Healing Arts**
Delivery Date:	**02/28/2019**

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

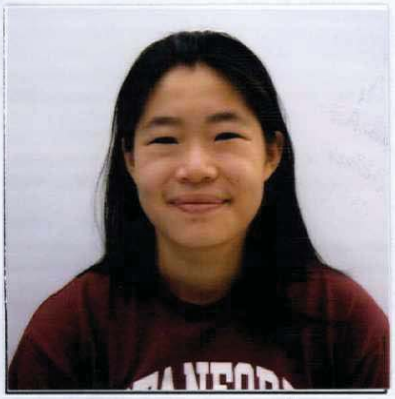
I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect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



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

GMH

Applicant's **Printed** Last Name

JESSICA W

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

12/2/15

Date of Signature (**must** correspond to date of notarization)

State of WA, County of KING,

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 2 day of DECEMBER, 2015.

Notary Public Signature: Nongnuch Paungpornsri

NONGNUCH PAUNGPORNSRI
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
SEPTEMBER 19, 2016

My Notary Commission Expires: September 19, 216

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

352266

215839259

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

fsmb

Biographic Information

Medical professional Name(s): **Guh, Jessica Wendy**

Date of Birth: [redacted]

Place of Birth: New London, CT, UNITED STATES

Contact Information

Home Address: [redacted]
UNITED STATES

Business Phone: (617) 460-0165

Mobile Phone: [redacted]

Email: [redacted]

Email: [redacted]

Email: [redacted]

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: GUH (Last) JESSICA (First) WENDY (Middle)

FCVS ID Number: 352266

Notary – Please complete the section below:

State of Washington County of King

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) 2nd, of (Month) December, (Year) 2015.

Notary Public Signature: Nongnuch Paungporn

Commission Expiration Date* (Month) September / (Day) 19 / (Year) 2016

*** 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

NONGNUCH PAUNGPORNSRI
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
SEPTEMBER 19, 2016

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

352266 PP

215839259

annexe 3


We the People
SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
PASSPORT
PASSEPORT
PASAPORTE
USA
UNITED STATES OF AMERICA
P
USA
[redacted]
GUH
JESSICA WENDY
UNITED STATES OF AMERICA
[redacted]
CONNECTICUT, U.S.A.
F
05 Feb 2009
04 Feb 2019
SEE PAGE 27
USA
P<USAGUH<<JESSICA<WENDY<<<<<<<<<<<<<<<<<<<<<<
[redacted]USA8409168F1902042181300050<711362

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
08/04/2008	05/11/2012	Medical Education	University of Michigan Medical School Ann Arbor Michigan UNITED STATES
06/25/2012	06/24/2013	Postgraduate Training	Swedish Medical Center/Cherry Hill Program Seattle Washington UNITED STATES
06/25/2013	06/24/2014	Postgraduate Training	Swedish Medical Center/Cherry Hill Program Seattle Washington UNITED STATES
06/25/2014	07/24/2015	Postgraduate Training	Swedish Medical Center/Cherry Hill Program Seattle Washington UNITED STATES
07/01/2015		Work	International Community Health Services 3815 S. Thello 2nd Fl Seattle, Washington UNITED STATES
06/01/2016		Work	SouthWestern Women's Surgery Center 8616 Greenville AVE 101 Dallas, Texas UNITED STATES

End of Chronology of Activities report for: Guh, Jessica Wendy

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **University of Michigan Medical School**

Location: Ann Arbor, MI

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 Rd
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: University of Michigan Medical School

Address Line 1:
1301 Catherine St

Address Line 2:
C-5124 MSI

City: Ann Arbor **State/Province:** MI **Zip Code (Postal Code):** 48109-5611
Country: US

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: *
Credential/degree presented by the applicant for admission to your medical school: B.A. / Stanford University

*Four years of high school education or equivalent and at least 90 semester hours of college coursework, of which 60 must be from an accredited U.S. based institution.

Enrollment and Participation: Our records indicate that Guh, Jessica
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 152 weeks of medical education on the following dates: **From:** 08/04/08 (Month Day Year) **To:** 04/27/12 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine (M.D.) on 05/11/12 (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, please print name and title.

Watermark
For FCVS internal use only.

Name: Antuan Featherstone
Signature: Antuan Featherstone
Title: Academic Records Coordinator
Date of Signature: 12/21/2015 Phone: (734) 936-1476
Fax: (734) 936-3510 Email: adavisfe@umich.edu

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ELECTRONIC SEAL VERIFIED

Unusual Circumstances

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

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:

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

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? ___ YES ✓ 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:

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

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? ___ 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 for behavioral reasons or an investigation by the medical school or parent university? ___ YES ✓ NO

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

_____

_____

___ YES ✓ NO

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?

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

_____

_____

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

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Medical School

Medical Professional Name: Guh, Jessica Wendy

University of Michigan Medical School

Unusual Circumstances

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: Guh, Jessica Wendy

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

University of Michigan Medical School

THE UNIVERSITY OF MICHIGAN
MEDICAL SCHOOL

Office of the Dean | M4101 MSI | 1301 Catherine Street, SPC 5624 | Ann Arbor, MI 48109-5624
(734) 763-9600 | www.med.umich.edu/medschool

December 14, 2015

Dean's Letter/Medical School Performance Evaluation Statement For Jessica Guh, M.D.

Recently, a request was received in the Office of Medical Student Education to submit to your office a Dean's Letter/Medical Student Performance Evaluation on behalf of one of our former students. The copy of the Dean's Letter/Medical Student Performance Evaluation that accompanies this statement was prepared early during the graduate's senior year at the University of Michigan Medical School. The descriptions of the student's personal and professional characteristics were compiled from evaluations submitted by the faculty of the various courses and clerkships of the Medical School curriculum. Positive aspects are emphasized, but negative assessments are also included. This letter is an accurate summary of the student's performance while in medical school.

If you require any additional information, please feel free to contact the Office of Student Programs at (734) 763-2380. Thank you.

University of Michigan Medical School

THE UNIVERSITY OF MICHIGAN
MEDICAL SCHOOL

Office of the Dean | M4101 MSI | 1301 Catherine Street, SPC 5624 | Ann Arbor, MI 48109-5624
(734) 763-9600 | www.med.umich.edu/medschool

Medical School Performance Evaluation for

Ms. Jessica Guh

November 1, 2011

Identifying Information

Ms. Jessica Guh is a senior medical student at the University of Michigan Medical School, Ann Arbor, Michigan.

Unique Characteristics

Ms. Guh came to us from Stanford University where she received her B.A. degree in Interdisciplinary Studies in the Humanities with a focus of film and society (received honors in Social Justice Documentary Film). She also served as a resident assistant with much student mentoring. Additionally, she engaged in clinical child psychiatry research, and in ecology research.

Between college and medical school she worked as a labor organizer for UNITE HERE (San Jose, CA) including work on healthcare benefits contract negotiations.

Since coming to our medical school and in addition to meeting curricular requirements, Ms. Jessica Guh has again engaged in numerous advocacy activities. These have included public health and healthcare surveys in Egypt (part of our Global REACH student organization); being a geriatrics assistant at the National Taiwan University Hospital (Taipei, Taiwan), and working with the Asian Health Services (Oakland, CA) which provides primary care services to low-income, linguistically isolated patients of Asian descent. She has also advocated within the American Medical Association and our Michigan State Medical Society, to increase access to essential medicines in developing countries. Associated with this kind of effort, she has been an executive board member for our chapter of Universities Allied for Essential Medicines. She has also been a leader in our student group, Bisexuals, Gays, Lesbians, and Allies in Medicine. She has served as a board member for our Medical Students for Choice group, and has been an online, published opinion/editorial columnist on issues of race, privilege and medicine, including creating her personal blog read by numerous individuals. She has been a leader in our American Medical Association chapter, been president of our Phi Chi Medical Fraternity, an executive board member of our Service Learning and Trans-disciplinary Education Project, plus facilitated monthly reading discussions on race and privilege. She has received several honors and awards throughout her academic career. As you can see, she is an impressively accomplished individual (please see her CV for more information)!

University of Michigan Medical School

www.med.umich.edu/medschool

Academic History

Matriculation Date: August 2008
AOA Awarded on: August 25, 2011
Anticipated Graduation Date: 05/11/2012
Leaves of Absence: None

Ms. Jessica Guh was not required to remediate or repeat medical school coursework.

Ms. Jessica Guh was not subject to any adverse actions by the University of Michigan Medical School or its affiliated teaching institutions.

Ms. Jessica Guh was elected to Alpha Omega Alpha Honor Society in her senior year.

Ms. Jessica Guh received the Clinical Skills Award.

Academic Progress

Ms. Jessica Guh successfully completed the first two years of medical school which are graded on a Satisfactory/Fail basis.

Clinical Clerkships

(Unedited, abridged comments)

Internal Medicine	**Honors**	**05/10/2010-08/01/2010**

[redacted]

University of Michigan
Medical School

www.med.umich.edu/medschool

[redacted]

Psychiatry	**High Pass**	**08/02/2010-09/12/2010**

[redacted]

Obstetrics/Gynecology	**High Pass**	**09/13/2010-10/24/2010**

[redacted]

Surgery	**High Pass**	**10/25/2010-12/19/2010**

[redacted]

Family Medicine	**High Pass**	**01/10/2011-02/06/2011**

[redacted]

[redacted]

Neurology	**Honors**	**02/07/2011-03/06/2011**

[redacted]

Pediatrics	**Honors**	**03/07/2011-05/01/2011**

[redacted]

Geriatrics Sub-I	**Honors**	**06/06/2011-07/03/2011**

[redacted]

Pediatrics, Developmental	**Honors**	**07/04/2011-07/31/2011**

[redacted]

Summary

Ms. Jessica Guh has successfully completed all of her medical school requirements to date. She has developed the skills and knowledge necessary to perform well in residency training. She has also demonstrated a high level of professionalism, moral character and adherence to ethical standards during medical school. Her overall clinical performance during her third year

clerkships, based largely on third year clerkship grades as of August 31, 2011 was outstanding. She was elected to AOA and received the Clinical Skills Award.

She was noted to stand out in terms of her clinical integrative skills, knowledge base, patient and staff interactions, hard work, teamwork, enthusiasm, organization skills, and presentation skills during the third year of medical school. She is a pleasure to work with! A holistic review of her available medical school record to date also demonstrated significant involvement in advocacy organizations, clinical research, community service, extracurricular activities, global outreach, health care for underserved populations, leadership and public health initiatives. Given this, I anticipate that Ms. Jessica Guh will make significant contributions to your residency program.

Sincerely,

David Gordon

David Gordon, M.D.
Associate Dean for Diversity and Career Development
Professor of Pathology

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL
Ann Arbor, Michigan

Medical Student Performance Evaluation
Appendix A

Since opening our doors in 1850, the University of Michigan Medical School has been a world leader in medical and basic science education, research and clinical care. As an integral part of the greater University of Michigan Health System (UMHS), our mission is to educate students, physicians and biomedical scholars through our top-ranked programs, and to provide a spectrum of comprehensive knowledge, research, patient care and the highest quality service to the people of the state of Michigan and beyond.

In addition to the Medical School and its Faculty Group Practice, UMHS includes three hospitals, approximately 40 health centers and 120 outpatient clinics, the U-M School of Nursing and the Michigan Health Corp. For more information about the University of Michigan Health System, visit http://www.med.umich.edu/1busi/sysorg.htm.

Every year, the Medical School carefully evaluates and assembles the newest incoming class. In the past four years, our incoming classes have had an average MCAT score of 11.66 and an average GPA of 3.76 (average science GPA has been 3.71). These classes have been made up of roughly the same number of in-state vs. out-of-state students, with about 47.9% and 52.1% in each group respectively, representing 43 states total. In addition, these classes have included students who have an advanced degree (11%) and who speak another language (53.8%; 19.3% speak three or more languages). While at U-M Medical School, an average of 16 students per year have earned dual degrees. The average combined Step 1 and 2 score from the past two years is 238.

The Medical Student Performance Evaluation (MSPE) provides the student's academic performance in comparison with peers at this institution. Additionally, the final MSPE summary statement reflects what we believe is the student's relative ranking to peer medical students on a national level.

Standard Medical School Program

The standard medical school curriculum has been developed to challenge students and to help them to mature cognitively and professionally. Beginning in the first year, students learn the material in relation to how they will use it as physicians: by reflecting on knowledge and facts, posing clinical questions, and using evidence to guide decision making. In addition to teaching the scientific principles of health and disease, the curriculum emphasizes patient communication, and the influence of cultural and social issues on health.

As part of our commitment to being a relevant and robust training ground for physicians and researchers, we continually challenge ourselves to become an academic institution with global impact. Students have access to opportunities for meaningful experiences in other countries, while also being exposed to and prepared for encountering an increasingly diverse society at home.

Throughout the four years of training, the curriculum is presented in sequences and modules that integrate biomedical sciences, clinical sciences, social/behavioral sciences and patient care skills. Graduates from

this program are ready to assume personal responsibility for their actions and decisions, learn throughout their lives, advocate for all patients, and provide the highest-quality medical care with the highest ethical standards.

Dual Degree Programs

The flexibility of the Medical School program affords students the opportunity and option to augment their medical training with a second graduate degree. The most common dual degree choice is the Medical Scientist Training Program (MSTP). MSTP is a combined M.D./Ph.D. degree program in which students spend at least three years in scholarly work and research toward their Ph.D. following the second year of medical school.

The University of Michigan also offers dual degree programs in the following areas:

- Oral Maxillofacial Surgery (M.D./O.M.F.S.)
- Public Health (M.D./M.P.H.)
- Business (M.D./M.B.A.)
- Information (M.D./M.S.I.)
- Public Policy (M.D./M.P.P.)
- Education (M.D./M.A.E.)
- Multidisciplinary Clinical Researchers in Training (MCRiT) Program (M.D./M.S.).

If the student was a dual degree candidate, a letter of recommendation from the director of the second degree program might also be attached.

Description of the Evaluation System and Grading

Currently, all first year and second year sequences, the Comprehensive Clinical Assessment Exams, the third year Seminars in Medicine course, and some career choice electives are graded Satisfactory/Fail. All other third year courses and most fourth year courses are graded Honors, High Pass, Pass, or Fail. Service learning, international clerkships and other rare fourth year electives are graded on a Satisfactory/Fail basis only.

For students who matriculated prior to 2004, all first year courses as well as Clinical Foundations, Family Centered Experiences, Longitudinal Cases and Introduction to the Patient courses in the second year and the third year Seminars in Medicine course were graded Satisfactory/Fail. All other courses were graded as Honors, High Pass, Pass, or Fail.

For third year graded clinical clerkships, the majority (50-75%) of the grade is based on clinical evaluations. All clerkships have a written final exam, usually the NBME Subject test (20-35% of grade). Essay exams oral exams, video exams, and/or final paper, along with participation, comprise the remainder of the grade in certain clerkships.

Recommended grade distribution:

- Honors for the top 15 – 20% of the class;
- High Pass for the next 40 – 45% of the class;
- Pass for the remaining 35 – 45% of the class.

The grade distribution document (Appendix B) is calculated on the grading basis in place for the academic year in which the student completed the course work.

The University of Michigan Medical School does not provide individual academic ranking data for students.

Special Recognition Awards

The University of Michigan Medical School only offers senior year AOA. Students are also eligible to receive many other departmental, distinction, and scholastic awards, but they are not presented until graduation.

Medical School Requirements

For promotion and graduation, all students must demonstrate satisfactory performance or passing grades in all sequences, courses, clerkships, rotations, and electives. In addition:

- A passing score on the USMLE Step 1 Exam is required for promotion to the third year.
- Passing scores on the USMLE Step 2 Clinical Knowledge and Clinical Skills Exams are required for graduation.
- Successful completion of the Comprehensive Clinical Assessment Exams, taken at the end of the second year and at the beginning of the fourth year, is required for graduation.

Clinical Clerkship Narrative Comments

Narrative comments from clinical faculty, and in rare cases senior residents, are included in the Medical Student Performance Evaluation. These representative comments are verbatim and unedited, but may be abridged to limit redundancy.

AAMC Guidelines for Medical Schools Regarding Academic Transcripts

The University of Michigan Medical School is in compliance with the Guidelines' recommendations with the exceptions that year M3 and M4 courses are not assigned numbers, and the USMLE policy for promotion, Family Education Rights and Privacy Act disclaimer, school accreditation status, and statement of authenticity are not included on the transcript.

Description of the Process Used to Compose the Medical Student Performance Evaluation:

The MSPE at the University of Michigan Medical School is prepared by one of five Medical School Associate or Assistant Deans. All medical students meet with a Dean early in the fourth year to review their background, *curriculum vitae*, personal statement, and career plans. Students have the opportunity to review the MSPE for accuracy but cannot change the content.

Students are designated in one of the following four categories after their third year clerkships on the MSPE Summary statement.

- **Outstanding** – a student with consistent, very high level academic performance who demonstrates superb clinical skills. *Assigned to approximately 22% of the 2012 graduating class.*

- **Excellent** – a student with consistent, above average academic performance who demonstrates excellent clinical skills. *Assigned to approximately 65% of the 2012 graduating class.*

- **Very Good** – a student with an average to above average academic performance who demonstrates good clinical skills. *Assigned to approximately 11% of the 2012 graduating class.*

- **Good** – a student with an average to below average academic performance who demonstrates competent clinical skills. *Assigned to approximately 2% of the 2012 graduating class.*

Please feel free to contact the UMMS Office of Medical Student Education at 734.764.0219, or email Charlotte Wojcik (wojcikc@umich.edu) or Susan Hayward (shayward@umich.edu) if you need additional information or assistance. We welcome your comments.

University of Michigan Medical School
Class of 2012 Grade Distribution
Appendix B

Guh, Jessica

M2 Courses

Student's grade within cohort is denoted by an asterisk (*).
Student Grade Percentage of Cohort Receiving Grade

Course	Credits	Honors	High Pass	Satisfactory/ Pass	Fail
Soc&Behav Iss in Med	3	CONFIDENTIAL			
Clinical Foundations	5				
Musculoskeletal	2				
Dermatology	1				
Cardiovascular	4				
Respiratory	3				
Neurosciences	5				
Gastrointestinal	6				
Reproduction	4				
Psychiatry	1				
Hematology/Oncology	5				
Endocrine	3				
Renal	4				

M3 Courses

Student's grade within cohort is denoted by an asterisk (*).
Student Grade Percentage of Cohort Receiving Grade

Course	Credits	Honors	High Pass	Satisfactory/ Pass	Fail
Obstetrics/Gynecology	6	CONFIDENTIAL			
Family Medicine	4				
Internal Medicine	12				
Psychiatry	6				
Neurology	4				
Surgery	8				
Pediatrics	8				
Seminars in Medicine	0				

** Represents a clerkship scheduled but not yet graded as of 08/01/2011.

Admitted to MEDICAL SCHOOL | Matriculated: 2008

Standard Program

Medical School Dates of Attendance:
Year:08-09 08/04/2008 05/31/2009
Year:09-10 08/17/2009 04/30/2010
Year:10-11 05/05/2010 05/01/2011
Year:11-12 05/09/2011 04/27/2012

THE UNIVERSITY OF MICHIGAN

ANN ARBOR

Degree:
Doctor of Medicine
Date conferred:
11-MAY-2012

Control #: M1451667-01TM01

Academic Record of:

Guh,Jessica

[redacted]

CONFIDENTIAL

Key: H = Honors
HP = High Pass
P = Pass
F = Fail
S = Satisfactory
U = Unsatisfactory
I = Incomplete
Y = Continuing Course
NC = No Credit
W = Official Withdrawal*
W/P = Withdrawal Passing
W/X = Withdrawal Extenuating Circumstances*
W/F = Withdrawal Failing
AP = Advanced Placement*
FM = Fail Marginal*
E = Senior Clerkship
(L) = Refer to line indicated

* Applies prior to 7/93 only
** Graded S/F/I or P/F/I

Effective: 9/95

Date issued: 14-DEC-2015

I, the undersigned, certify that this is a true copy of the original University of Michigan Medical School Diploma for:

Jessica Wendy Guh

Crystal D. Napier, Medical School Registrar — Dec 21, 2015

ELECTRONIC SEAL VERIFIED

THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL 1817

Universitatis Reipublicae Michigandensis

PROCURATORES OMNIBUS HAS LITERAS PERLECTURIS

Salutem

Jessica Wendy Guh

Sciatis ..... *ingenuis moribus nobis a Collegii Medicinae et Chirurgiae Professoribus commendatam, ut quae in studio et disciplina scientiaque Medicinae et Chirurgiae Artium bene probata sit, gradu*

Doctoris in Arte Medica

nos ornavisse, cujus in rei testimonium has literas, Praesidis et Secretarii et Professorum nomina manusque gerentes, sigilloque Universitatis signatas, in manus ejusdem dedimus.

Datum ex aedibus Universitatis die primo decimo Maii anno salutis bis millesimo undecimo Annoque Universitatis Reipublicae Michiganensium centesimo nonagesimo quinto.

Sally J. Churchill — *Praesos Vicarius et Secretarius*

Mary Sue Coleman — *Praesos*

Professores

- ..... — *Decanus*
- ..... — *Dermat. Prof.*
- ..... — *Anesthesiol. Prof.*
- ..... — *Radiol. Prof.*
- ..... — *Art. Obst. et Gynaecol. Prof.*
- ..... — *Pharmacol. Prof.*
- ..... — *Oncol. per Radiat. Prof.*
- ..... — *Art. Succenturiatus Medicinae Prof.*
- ..... — *Chirurg. Prof.*
- ..... — *Collorum et Mediastinarum Pulm. Prof.*
- ..... — *Educatio Medicis. Prof.*
- ..... — *Chem. Biol. Prof.*
- ..... — *Art. Pediatr. et Morb. Contag. Prof.*
- ..... — *Orthopaed. Chirurg. Prof.*
- ..... — *Neurol. Prof.*
- ..... — *Microbiol. et Immunol. Prof.*
- ..... — *Neurochirurg. Prof.*
- ..... — *Hum. Gen. Prof.*
- ..... — *Path. Prof.*
- ..... — *Phy. Med. et Pediat. Prof.*
- ..... — *Urol. Prof.*
- ..... — *Physiol. Molec. et Integrat. Prof.*
- ..... — *Otorhinolaryngol. Prof.*
- ..... — *Art. Med. Prof.*
- ..... — *Psychiatr. Prof.*
- ..... — *Ophthalmol. et Visualis Scient. Prof.*
- ..... — *Chirurgiae pectoralis Prof.*
- ..... — *Medicinae Computationalis et Bioinformaticorum Prof.*
- ..... — *Art. Famil. Med. Prof.*

MEDICAL SCHOOL
UNIVERSITY OF MICHIGAN

Office of Medical Student Education
Student Services
Medical Science Bldg I C Wing # 5124
1301 Catherine St, SPC 5611
Ann Arbor, Michigan 48109
734 764-0219
734 936-3510 fax

The University of Michigan Medical School
Official English Translation of Diploma
Class of 2012

The enclosed University of Michigan Medical School diploma was presented to the named student on May 11, 2012. This diploma reads as follows when translated into the English language:

From the Regents of the University of Michigan, to all who may read this document, Greetings:

Since Jessica Wendy Guh, M.D., has been recommended to us by the Professors of the College of Medicine and Surgery in their distinguished fashion as one whose enthusiasm, zeal, and knowledge of the arts of Medicine and Surgery are well established, know that we have honored her with the degree of Doctor of Medicine; in testimony of this we have granted her this document bearing the names and signatures of the President, Secretary, and Professors, and signed with the seal of the University.

Given at the University on the 11th day of May in the 2012th year of our health and 195th year of the University of Michigan.

Crystal D. Napier, Registrar
University of Michigan Medical School

ELECTRONIC SEAL VERIFIED

Please recycle

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: **1205421328**

Institution: **Swedish Medical Center/Cherry Hill Program**

Location: Seattle, WA
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Swedish Family Medicine Cherry Hill

Attention: **Program Director**

Specialty: Family Medicine

Affiliated University: _____

Address: Seattle, WA

Verification For:

Name: Guh, Jessica

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: PGY1 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: Family Medicine
From: 6/25/12 **To:** 6/24/13
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: PGY2 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: Family Medicine
From: 6/25/13 **To:** 6/24/14
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: PGY3 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: Family Medicine
From: 6/25/14 **To:** 6/24/15
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:

_____

_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this [illegible] 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: Paul Gianutsos, MD, MPH

Signature: Paul Gianutsos, MD, MPH

Title of Signatory: Program Director

Date of Signature: 1/12/16

Tel: 206-320-2233 Fax: 206-320-8173 E-Mail: ryan.spady@swedish.org

ELECTRONIC SEAL VERIFIED

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Guh, Jessica Wendy
Accreditation ID:	1205421328
Institution:	Swedish Medical Center/Cherry Hill Program
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 6/25/2012 - 6/24/2013 **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**

Unusual Circumstances

Training Period: 6/25/2013 - 6/24/2014 **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**

Unusual Circumstances

Training Period: 6/25/2014 - 7/24/2015 **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**

Applicant Reported Unusual Circumstances

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: Guh, Jessica Wendy

CHERRY HILL CAMPUS
550 16th Ave., Suite 100
Seattle, WA 98122
T 206.320.2484
www.swedish.org

SWEDISH
FAMILY MEDICINE

June 9, 2015

RE: Jessica Guh, MD
Procedural competency

To Whom It May Concern:

Dr Guh will graduate from a fully accredited ACGME residency program in Family Medicine on June 24, 2015. She is competent to perform a wide variety of procedures in the office and the hospital including, but not limited to:

IUD placement and removal
Knee and shoulder injections
Lumbar puncture
Medical abortion
Nail removal
Newborn circumcision
Nexplanon
OB US in 1st and 3rd trimester
Paracentesis
Skin biopsies
Skin excisions
Surgical abortion to 17 weeks
Upper and lower extremity casting and splinting

Sincerely,

Paul Gianutsos, MD, MPH
Program Director

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: 02/28/2019

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 442143

Examinee: Guh, Jessica Wendy
Alt Name(s):

Examinee ID: 5-237-557-3
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
04/26/2010	Pass	[redacted]	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/03/2011	Pass	[redacted]	(189)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
10/05/2011	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
02/03/2014	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: Guh, Jessica Wendy

Examinee ID: 5-237-557-3
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:2/28/2019

PRACTITIONER INFORMATION

Name:	Guh, Jessica Wendy
DOB:	[redacted]
Medical School:	University of Michigan Medical School Ann Arbor, Michigan, UNITED STATES
Year of Grad:	2012
Degree Type:	MD
NPI:	1851652135

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
TEXAS	Q8496	06/01/2016	08/31/2020	02/01/2019
WASHINGTON	ML60288612	05/30/2012	06/20/2014	01/31/2019
WASHINGTON	MD60467205	06/20/2014	09/14/2019	01/31/2019

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:2/28/2019
Practitioner Name:	Guh, Jessica Wendy	

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Family Medicine
Certificate:	Family Medicine
Certification Type:	General
Certification Status:	Certified
Participating in MOC:	Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	06/25/2015		02/15/2019	Initial	01/31/2019

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

NPDB Report

GUH, JESSICA WENDY **DCN: 5500000144096755**

FOR AUTHORIZED USE BY: Kansas State Board of Healing Arts

Process Date: 2/28/2019

The following is a render of data received by National Practitioner Data Bank (NPDB) as interpreted by FSMB

GUH, JESSICA WENDY

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name:	GUH, JESSICA WENDY
Date of Birth:	[redacted]
Gender:	FEMALE
Work Address:	TRUST WOMEN FOUNDATION 5107 E KELLOGG DR WICHITA, KS 67218
Home Address:	[redacted]
National Provider Identifiers (NPI):	[redacted]
License(s):	Physician (MD), Q8496, TX
Professional School(s):	UNIVERSITY OF MICHIGAN MEDICAL SCHOOL (2012)

B. QUERY INFORMATION

Statutes Queried:	Title IV, Section 1921, Section 1128E
Query Type:	This is a One-Time query response. Your organization will only receive future reports on this practitioner if another query is submitted.
Entity Name:	Kansas State Board of Healing Arts
Authorized Agent:	Federation of State Medical Boards, (817) 868 - 4000
Customer Use:	215839259

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 2/28/2019

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

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

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:

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

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.

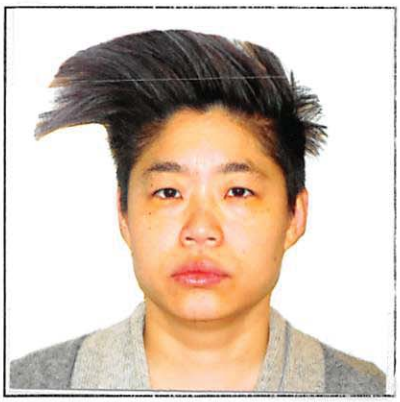
I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being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



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

GUH
Applicant's printed last name

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

5/7/19
Date of signature (must correspond to date of notarization)

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. — fold up

Notary

State of Washington, County of King

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 7th day of May, 2019.

Notary Public Signature: N S Bae

My Notary Commission Expires: 04/10/2022

N S BAE
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
APRIL 10, 2022
(NOTARY PUBLIC SEAL)

[redacted]

SEATTLE WA 980

KANSAS STATE BOARD OF HEALING ARTS
800 SW JACKSON, LOWER LEVEL - SUITE A
TOPEKA, KS 66612

RECEIVED
MAY 13 2019
KSBHA

66612-124473

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: Family Medicine

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 WICHITA
3. Primary Specialty FAMILY MEDICINE

   American Board Certified ✓ American Board Eligible _____
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: Admin
To: Koelling, Michelle [BOHA]
Subject: Re: KS License
Date: Thursday, April 25, 2019 4:30:02 PM
Attachments: Outlook-1462990329.png
Image_01436.pdf
Image_01437.pdf
Image_01438.pdf
Image_01435.pdf

[redacted] CONFIDENTIAL [redacted]

Admin has shared OneDrive for Business files with you. To view them, click the links below.

Image_01436.pdf Image_01437.pdf Image_01438.pdf

Image_01435.pdf

[redacted]

[redacted]

[redacted]

[redacted]

TRUST WOMEN
SOUTH WIND WOMEN'S CENTER

[redacted]

From: Koelling, Michelle [BOHA] <Michelle.Koelling@ks.gov>
Sent: Wednesday, March 20, 2019 10:18:01 AM
To: Admin
Subject: KS License

[redacted]
CONFIDENTIAL
[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[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. ☐ Yes ☒ No 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. ☐ Yes ☒ No 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?

12. CONFIDENTIAL Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?

13. CONFIDENTIAL Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?

14. CONFIDENTIAL Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?

15. CONFIDENTIAL Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?

16 CONFIDENTIAL Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?

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?

From: Admin
To: Koelling, Michelle [BOHA]
Subject: Re: KS License
Date: Thursday, April 25, 2019 4:30:02 PM
Attachments: Outlook-1462990329.png
Image_01436.pdf
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[redacted] CONFIDENTIAL [redacted]

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[redacted]

[redacted]

[redacted]

[redacted]

TRUST WOMEN
SOUTH WIND WOMEN'S CENTER

[redacted]

From: Koelling, Michelle [BOHA] <Michelle.Koelling@ks.gov>
Sent: Wednesday, March 20, 2019 10:18:01 AM
To: Admin
Subject: KS License

[redacted]
CONFIDENTIAL
[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

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): Jessica Guh **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. Jessica Guh (type or print) for 7 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. Jessica Guh is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: ANUJ KHATTAR

Profession: Please select one: MD ☒ DO ☐

Street 1: [redacted]

Street 2:

State/Zip:

Telephone:

Signature:

Date: 5/7/19

[redacted]

TACOMA WA 983
OLYMPIA WA
09 MAY 2019 PM 4 L

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

RECEIVED
MAY 14 2019
KSBHA

66612-121699

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): Jessica Guh **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. Jessica Guh (type or print) for 7 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. Jessica Guh is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Jennifer Abrams

Profession: Please select one: MD ☒ DO ☐

Street 1: [redacted]

Street 2:

State/Zip:

Telephone:

Signature: [signature], MD

Date: 5/9/2019

[redacted]

DENVER CO 802

09 MAY 2019 PM 9 L

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

66612-124473

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Uniform Application for Physician State Licensure	As of Date:2/26/2019

PRACTITIONER INFORMATION

Name:	Guh, Jessica Wendy
DOB:	[redacted]
Medical School:	University of Michigan Medical School Ann Arbor, Michigan, UNITED STATES
Year of Grad:	2012
Degree Type:	MD
NPI:	1851652135

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
TEXAS	Q8496	06/01/2016	08/31/2020	02/01/2019
WASHINGTON	ML60288612	05/30/2012	06/20/2014	01/31/2019
WASHINGTON	MD60467205	06/20/2014	09/14/2019	01/31/2019

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Uniform Application for Physician State Licensure

As of Date:2/26/2019

Practitioner Name: Guh, Jessica Wendy

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Family Medicine
Certificate:	Family Medicine
Certification Type:	General
Certification Status:	Certified
Participating in MOC:	Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	06/25/2015		02/15/2019	Initial	01/31/2019

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

G [redacted]

KANSAS STATE BOARD OF HEALING ARTS
800 SW JACKSON, LOWER LEVEL SUITE A
TOPEKA, KS 66612

DO NOT BEND

AMA Physician Profile

PREPARED FOR

Kansas State Board of Healing Arts, Topeka, KS

Name and Mailing Address

JESSICA WENDY GUH
[redacted]

Primary Office Address

INTERNATIONAL COMMUNITY HEALTH SERVICES
STE 200
3815 S OTHELLO ST
SEATTLE, WA 98118-3510
Phone (206) 788-3500

Birth date [redacted]

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty FAMILY MEDICINE (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
1851652135	06/04/2012	NOT RPTD	NOT RPTD	NOT RPTD	02/15/2019

Current and/or historical medical school

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

Degree Awarded: YES

Degree Year: 2012

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: SWEDISH MEDICAL CENTER
Sponsoring State: WASHINGTON
Program name: SWEDISH MEDICAL CENTER/CHERRY HILL PROGRAM
Specialty: FAMILY MEDICINE
Training Type:
Dates: 6/2012 - 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: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY MEDICINE
Certificate type: GENERAL

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
MOC+	Active	06/25/2015	n/a	02/15/2020	INITIAL	03/07/2019	Y

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.

+The above certifying board has implemented standards which specify that the board certification is contingent upon meeting ongoing requirements of Maintenance of Certification (MOC). Only certificates issued by a MOC participating board will reflect a reverification date.

Current and/or historical medical licensure

License No.	MD / DO	Jurisdiction	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported
Q8496	MD	TX	06/01/2016	08/31/2020	06/15/2016	ACTIVE	UNLTD	03/04/2019
MD60467205	MD	WA	06/20/2014	09/14/2019	08/21/2017	ACTIVE	UNLTD	03/01/2019
ML60288612	MD	WA	05/30/2012	06/20/2014	06/20/2013	INACTIVE	LTD	03/01/2019

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
XXXXXX660	22N 33N 4 5	09/30/2021	03/11/2019	International Community Health Services Ste 200 3815 S Othello St Seattle, WA 98118-3510

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
By KSBHA at 1:54 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: Jessica Guh, MD

TO WHOM IT MAY CONCERN:

[redacted]

To document our records, the Plan also requests the Board provide to us a copy of the New Licensure letter sent to the applicant upon approval of issuance of their Kansas license. To facilitate this request, attached is an authorization signed by Dr. Guh.

Please note this Letter of Intent confers no conditions or obligations on the Plan to provide notice should Dr. Guh make the decision not to purchase Plan coverage.

Please do not hesitate to contact the Underwriting Department with questions.

Sincerely,

Sara Patry
Underwriter

/enc

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 JESSICA GUH

Address [redacted]

[redacted]

Signed _____ Date 1/16/19

From: Sara Patry
To: Barnes, Lori [BOHA]; Bohannon, Ronda [BOHA]
Subject: Jessica Guh, MD - letter of intent attached
Date: Thursday, April 4, 2019 10:50:13 AM
Attachments: 2019_04_04_10_49_01.pdf

EXTERNAL: This email originated from outside of the organization. Do not click any links or open any

[redacted] CONFIDENTIAL

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[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: 580867
580875
580876

DATE: 03/01/2019

NAME:	LICENSE TYPE:	FEE:	LIC #:
Jessica Wendy Guh	MD	$300	03-09-2019
Jessica Wendy Guh	MD	$47	03-09-2019
Jessica Wendy Guh	MD	$3	03-09-2019

AMOUNT: 300.00 TYPE: Credit Card CH/CC #: 012021

RECEIVED FROM:

Jessica Wendy Guh
[redacted]

[redacted]

Moon, Rebekah [BOHA]

From: Lizeth Lucio <LLucio@itrustwomen.org>
Sent: Wednesday, February 27, 2019 5:03 PM
To: KSBHA_InitialLicense
Cc: Julie Burkhart
Subject: License fees
Attachments: Image_01050.pdf; Image_01051.pdf

CONFIDENTIAL

[redacted]

ADDENDUM 4
KANSAS STATE BOARD OF HEALING ARTS

Applicant: Complete this form and email it to boardinquiry@fsmb.org. You must also check the box below.

☒ I hereby certify that I am the individual referenced below and I acknowledge that I have answered all questions and reported all information on this page truthfully and completely.

Federation of STATE MEDICAL BOARDS

Federation of State Medical Boards of the United States, Inc.
400 Fuller Wiser Road, Suite 300 | Euless, TX 76039
Tel (817) 868-4000 Fax (817) 868-4099

Physician Data Center Inquiry Form

Attention: State Board Inquiries

The Kansas State Board of Healing Arts is requesting a PDC Search concerning the following individual:

Last Name GUH

First Name JESSICA

Middle Name WENDY

Date of Birth [redacted]

Daytime Phone [redacted]

Email [redacted]

Degree (MD, DO, or PA only) MD

Medical School UNIVERSITY OF MICHIGAN

Year of Graduation 2012

Last Four Digits of Social Security Number [redacted]

ECFMG # (if applicable) _____

NPI Number [redacted]

Please mail the result to the following address:

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

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Uniform Application – Core Application

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: GUH Suffix: _____

First name: JESSICA

Middle name: WENDY

Maiden name (if applicable): _____

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: _____

_____

City: _____

State/Province: _____

Zip code: _____ Country: _____

Practice phone: _____ Practice fax: _____

Alternate phone: _____ Alternate fax: _____

Practice email: _____

Home Address

☐ Public Access
☒ Mailings for Medical Board

Street: [redacted]

_____

City: [redacted]

State/Province: VA

Zip code: 98118 Country: USA

Home phone: [redacted] Home fax: _____

Alternate phone: _____ Alternate fax: _____

Home email: [redacted]

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] (mm/dd/yyyy) Gender: F Birth city: NEW LONDON

Birth state/province: CT Birth country: USA

Social Security number [redacted] (9 digits) NPI number**: [redacted] (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/

Applicant Name: _____

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: UNIVERSITY OF MICHIGAN

Street: 1301 CATHERINE ST

City: ANN ARBOR State/Province: MI Zip code: 48109

Country: USA Attendance dates: From 8/2008 (mm/yyyy) to 5/2012 (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): 06/01/2012 (mm/dd/yyyy)

Degree received (as stated on diploma): MD (indicate if not applicable)

2. Full Name of Medical School: _____

Street: _____

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

Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): _____ (mm/dd/yyyy)

Degree received (as stated on diploma): _____ (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: _____

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: SWEDISH MEDICAL CENTER

Street: 550 16TH AVE SUITE 400

City: SEATTLE State/Province: WA Zip code: 98122

Country: USA Department/Specialty: FAMILY MED - CHERRY HILL

Affiliated medical school name: N/A

Attendance dates: From 06/2012 (mm/yyyy) to 06/2015 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 1-3

- ☐ 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: _____

Street: _____

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

Country: _____ Department/Specialty: _____

Affiliated medical school name: _____

Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): _____

- ☐ 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: _____

Street: _____

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

Country: _____ Department/Specialty: _____

Affiliated medical school name: _____

Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): _____

- ☐ 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: _____

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		☒ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CS		☒ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CK		☒ (P) ☐ (F) ☐ (U)	1
USMLE Step III		☒ (P) ☐ (F) ☐ (U)	1
State Board Exam State: WA		☒ (P) ☐ (F) ☐ (U)	1
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: MD60467205 Issue date: 8/21/17

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

Applicant Name: _____

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: TX License number: Q8496 Issue date: 6/1/16

License status: ☒ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ 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: _____ License number: _____ Issue date: _____

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

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 ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ 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 ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

Applicant Name: _____

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: 06/2012 (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*: SWEDISH MEDICAL CENTER

Street: 550 16TH AVE SUITE 400

City: SEATTLE State/Province: WA Zip code: ~~98122~~ 98122

Country: USA Position: RESIDENT PHYSICIAN

Department: FAMILY MEDICINE Clinical**: 100 % Administrative***: ____ %

☒ Employment ☐ Staff Privileges ☐ Affiliation

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

2. Start date: 07/2015 (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*: INTERNATIONAL COMMUNITY HEALTH SERVICES

Street: 3815 S. OTHELLO 2ND FL

City: SEATTLE State/Province: WA Zip code: 98118

Country: USA Position: PHYSICIAN / RESIDENCY DIRECTOR

Department: FAMILY MEDICINE Clinical**: 60 % Administrative***: 40 %

☒ Employment ☐ Staff Privileges ☐ Affiliation

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

3. Start date: 06/2018 (mm/yyyy) End date: 07/2018 (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*: SOUTHWESTERN WOMENS SURGERY CENTER

Street: 8616 GREENVILLE AVE #101

City: DALLAS State/Province: TX Zip code: 75243

Country: USA Position: PHYSICIAN

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

☐ Employment ☐ Staff Privileges ☐ Affiliation

☒ Other (describe your relationship with this institution): CONTRACTOR

Applicant Name: _____

Copy and attach additional pages as necessary.

4. 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): _____

5. 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): _____

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.

Applicant Name: _____

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
- ☐ 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.

From: Admin
To: Koelling, Michelle [BOHA]
Subject: Re: KS License
Date: Friday, May 17, 2019 4:30:20 PM
Attachments: Outlook-1462990329.png
Application.pdf

[redacted] CONFIDENTIAL
CONFIDENTIAL

[redacted]

Admin has shared a OneDrive for Business file with you. To view it, click the link below.

Application.pdf

[redacted]

[redacted]

[redacted]

[redacted]

TRUST WOMEN
SOUTH WIND WOMEN'S CENTER

[redacted]

From: Koelling, Michelle [BOHA] <Michelle.Koelling@ks.gov>
Sent: Wednesday, March 20, 2019 10:18:01 AM

To: Admin
Subject: KS License

[redacted]
CONFIDENTIAL
[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

From: Admin
To: Koelling, Michelle [BOHA]
Subject: Re: KS License
Date: Friday, May 17, 2019 4:32:33 PM
Attachments: Outlook-1462990329.png
Outlook-1462990329.png
ICHS-Holly-Park-Jessica-Guh-610x854.jpg

[redacted] CONFIDENTIAL [redacted]

[redacted]

Admin has shared a OneDrive for Business file with you. To view it, click the link below.

ICHS-Holly-Park-Jessica-Guh-610x854.jpg

[redacted]

[redacted]

[redacted]

TRUST WOMEN
SOUTH WIND WOMEN'S CENTER

[redacted]

[redacted]

[redacted]

[redacted] CONFIDENTIAL

[redacted]

[redacted]

[redacted]

From: Koelling, Michelle [BOHA] <Michelle.Koelling@ks.gov>
Sent: Wednesday, March 20, 2019 10:18:01 AM
To: Admin
Subject: KS License

[redacted] CONFIDENTIAL [redacted]

[redacted]

[redacted]

CONFIDENTIAL

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]