Application #: 1425024 MD/DO – Worksheet

Analyst Initials CB Reviewed/Entered in MLO Date 10/17/18 Routing Box started x

Applicants Name Lehman Wiens, Ruth Mary-MD SS# [redacted] Applied fees x

x Application Fee Receipt # 567875 Check/MO # _____ Credit Card x

x KBI Report Fee Receipt # 567876 Check /MO# _____ Credit Card x

x NPDB Fee Receipt # 567877 Check/MO # _____ Credit Card x

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x **(1app)** Application x Name Change Doc.
Home Add x Prac Add x NPI x
Chronology of Activities x

n/a **(2FCVS) Using FCVS**

_____ **(3sch)** Professional School Verification

_____ **(4trans)** Medical School Transcripts University of KS School of Med

_____ **(5diplm)** Medical School Diploma

n/a **(6ecfmg)** ECFMG Report
(Foreign Trained Only) _____

x **(8pgrad)** Postgrad Program Verifications
(US grad min 1yr, IMG min 2yrs.ACGME)

Postgrad Programs/Dates	Rec
Wesley Medical Center 07/17-07/20	x
_____	__
_____	__
_____	__
_____	__
_____	__

x **(9exam)** Exams: USMLE
Nat'l Board/Flex/USMLE (*completed within 10 yrs.)

x **(10stverf)** Verification Other Licenses:
KS#94-09239, _____

x **(11Photo)** Affidavit/Release/Photo

x Addendum #1 License Designation x
Statement of Health x

x **(13 Dis Q's)** Addendum #2 Disc Question(s)____

n/a **(14supportingdocs)** Supporting Documents____

x **(15rec)** Addendum #3 Prof. Rec.: 1 x 2 x

_____ **(16 Fedrt)** Addendum #4 Federation Report
(also called Practitioner Profile) _____

x Addendum #5 Waiver

x Fingerprint Card: received 10/15/18 sent 10/18/18

_____ **(19KBI)** Criminal Background Report

x **(20AMA or AOIA)** AMA/AOIA Report
AMA

_____ **(21NPDB)** NPDB Report: sent 10/18/18 received____

_____ **(22 prelease)** Release to person/organization

x **(23wrkst)** Worksheet

x **(24addtl)** Additional Information

Missing Requirements: 3sch, 4trans, 5diplm, 16fedrt, _____

AMA/AOIA Folder___ Federation Folder ___FCVS Folder___ License Verification Folder___ Missing Req. Folder___

E-transcripts Folder___ Affidavit Folder___ Excel KBI___ Excel NPDB___ Entered comments in comment boxes___

Renamed in Build an Application to Applicant ID# ___ Bookmarked___ Completed MRL letter___

App Rec'd 10/15/18 Sent to Legal_____ Returned to Analyst_____ Lic Approved_____

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Uniform Application – Core Application

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

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

Full Name

Last name: Lehman Wiens Suffix: _____

First name: Ruth

Middle name: Mary

Maiden name (if applicable): Wiens

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: 950 N Hillside St

City: Wichita

State/Province: KS

Zip code: 67214 Country: USA

Practice phone: 3169823070 Practice fax: _____

Alternate phone: 316 962 2000 Alternate fax: _____

Practice email: _____

Home Address

☐ Public Access
☒ Mailings for Medical Board

Street: [redacted]

City: [redacted]

State/Province: KS

Zip code: 67220 Country: USA

Home phone: [redacted] me 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: Newton

Birth state/province: Kansas Birth country: USA

Social Security number*: [redacted] (9 digits) NPI number**: 1861921611 (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/

Katherine Kellerman
KATHERINE KELLERMAN
Notary Public - State of Kansas
My Appt. Expires 2-4-2020

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Department of Health - Vital Statistics

STATE OF FLORIDA
MARRIAGE RECORD

TYPE IN UPPER CASE
USE BLACK INK

(STATE FILE NUMBER)

This license not valid unless seal of Clerk, Circuit or County Court, appears thereon

Katherine Kellerman

KATHERINE KELLERMAN
Notary Public - State of Kansas
My Appt. Expires 2-4-2020

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CIRCUIT COURT SARASOTA COUNTY FLORIDA

"STATE OF FLORIDA, COUNTY OF SARASOTA
I hereby certify that the foregoing is a true and correct copy of pages 1 through 1 of the instrument filed in this office. The original instrument filed contains 1 pages.
☒ This copy has no redactions. ☐ This copy has been redacted pursuant to law.
Witness my hand and official seal this 17 day of February, 2015."
KAREN E. RUSHING, CLERK OF THE CIRCUIT COURT
By: _____ Deputy Clerk

CONFIDENTIAL

[redacted]

DH 743, 4/98 (Replaces Feb, 91 edition) Stock # 5740-000-0743-8

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Applicant Name: Ruth Lehman Wiens

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 Kansas School of Medicine

Street: 1010 N Kansas St

City: Wichita State/Province: KS Zip code: 67214

Country: USA Attendance dates: From 07/2013 (mm/yyyy) to 05/2017 (mm/yyyy)

Date degree conferred/issued (indicate if not applicable): 05/14/2017 (mm/dd/yyyy)

Degree received (as stated on diploma): Doctor of Medicine (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: Ruth Lehman Wiens

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: Wesley Medical Center
Street: 550 N Hillside St
City: Wichita State/Province: KS Zip code: 67214
Country: USA Department/Specialty: Family medicine
Affiliated medical school name: University of Kansas
Attendance dates: From 07/2017 (mm/yyyy) to 07/2020 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 2

☐ 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 07/2020 (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)

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Applicant Name: Ruth Lehman Wiens

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	05/2015	☒ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CS	07/2016	☒ (P) ☐ (F) ☐ (U)	1
USMLE Step II, CK	07/2016	☒ (P) ☐ (F) ☐ (U)	1
USMLE Step III	06/2018	☒ (P) ☐ (F) ☐ (U)	1
State Board Exam			
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	

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

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

State/Province Professional Licensure

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

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

State/Province: Kansas License number: 94-09239 Issue date: 7/1/2017

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

Applicant Name: Ruth Lehman Wiens

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: 05/2017 (mm/yyyy) End date: 07/2017 (mm/yyyy)

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

Practice/Employment Name **or** Description of non-working time*: preparing for residency

Street:

City: State/Province: Zip code:

Country: Position:

Department: Clinical**: ___% Administrative***: ___%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

2. Start date: 07/2017 (mm/yyyy) End date: present (ending 07/2020) (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*: Wesley Family Med Residency - KU School of Medicine

Street: 850 N Hillside

City: Wichita State/Province: KS Zip code: 67214

Country: USA Position: Resident

Department: family medicine Clinical**: 80 % Administrative***: 20 %

☒ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

3. 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):

Applicant Name: Ruth Lehman Wiens

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.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Medical School Verification (UA Form #2)

Applicant: Complete this form as instructed in the left sidebar.
Dean or Designated Med School Official: Complete as instructed in the left sidebar.

Applicant:

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

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

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

Section 1: Applicant Information

Last name: Lehman Wiens Suffix: MD

First name: Ruth

Middle name: Mary

Name if different when diploma awarded: _____

Name of medical school: KU School of Medicine - Wichita

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

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

Waiver for Release of Information: I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

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

Applicant signature: _____ Date: 9/19/18

Dean or Designated Official:

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the Kansas State Board of Healing Arts at the address listed in Section 1. Do not mail this form to FCVS/FSMB.

If transcripts are not in English, an original, certified, and official English translation is required.

Section 2: Medical School Verification

Medical school name: The University of Kansas

School name if different when the above applicant attended: _____

Medical school address (including city, state or province, zip code, and country as applicable):

3901 Rainbow Blvd

Kansas City KS 66160

Hours of undergraduate education required for admission into your school: Bachelors / 4 years

Total weeks of education applicant attended your school: 144

Applicant's attendance dates: From 07/29/2013 to 05/06/2017

Graduation date: 05/14/2017 (indicate N/A if not applicable) Degree: Doctor of Medicine (indicate N/A if not applicable)

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

Applicant Name: Ruth Lehman Wiens

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes ☐ No ☒

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

	From Month/Year	To Month/Year	Approved	Unapproved
☐ Personal/Family			☐	☐
☐ Academic remediation			☐	☐
☐ Health			☐	☐
☐ Financial			☐	☐
☐ Participation in joint degree program (e.g., MD/PhD)			☐	☐
☐ Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
☐ Other:			☐	☐

2. Do the official records for this individual 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 date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
☐ Academic probation		
☐ Probation for unprofessional conduct/behavioral reasons		
☐ Probation for other reason(s) (please specify):		

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

   If yes, please attach documentation/information of the circumstances and outcome(s).

4. Do the official records for this individual 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 attach documentation/information of the circumstances and outcome(s).

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

   If yes, please attach documentation/information of the nature of the limitations or special requirements.

** The Office of the Registrar does not maintain this information.

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

SEALED VERIFIED KSBHA

AFFIX INSTITUTIONAL SEAL HERE

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

Signature: Caroline Scala

Print name: Caroline Scala

Title: Associate Registrar

Date: 10/16/2018

Phone number: 913-588-7055 Fax number: 913-588-8841

Email: kumcregistrar@kumc.edu

University of Kansas
Lawrence, KS

Official KU Academic Record

Name: Ruth Lehman Wiens
Student ID: 2283039

[redacted]

To

CONFIDENTIAL

Tiffany Robinson
University Registrar

RAISED SEAL NOT REQUIRED

This Official Transcript is printed on tamper-proof security paper and does not require a raised seal. To confirm authenticity, see instructions on reverse side.

The University of Kansas

Office of the University Registrar
KU Visitor Center, 1502 Iowa Street
Lawrence, KS 66045-7576
(785) 864-4423

KEY TO TRANSCRIPT OF ACADEMIC RECORDS

Campus Locations:
University of Kansas - Lawrence
Main, Edwards & West Campus
KU Visitor Center, 1502 Iowa Street
Lawrence, KS 66045-7576
(785) 864-4423

University of Kansas - Medical Center
3901 Rainbow Blvd.
Mail Stop 4029
Kansas City, KS 66160
(913) 588-1048

Accreditation: The University of Kansas is accredited by the North Central Association of Colleges and Secondary Schools as a degree-granting institution at the baccalaureate, master, professional and doctoral levels.

Issuing of Academic Transcripts: University of Kansas official academic transcripts are produced and issued by the Office of the University Registrar and the University of Kansas Medical Center, Office of the Registrar.

Release of Information: This document cannot be released to a third party without the written consent of the student in accordance with the Family Educational Rights and Privacy Act of 1974, as amended.

Academic Calendar: The University of Kansas calendar is based on the semester system. A standard semester contains at least 16 weeks of instruction, including final exams. Summer sessions vary in length.

USMLE: Degree Requirements for School of Medicine students include a passing score on USMLE Step 1 and Step 2.

Student Levels as defined by hours:
Freshmen 0-29 hours
Sophomore 30-59 hours
Junior 60-89 hours
Senior 90 hours and up

Grade Point Average (GPA)
The GPA is the quotient obtained by dividing the number of grade points earned by the number of hours attempted. University of Kansas Academic policy states that the GPA may be computed for an entire academic record or for any segment thereof. GPA's reflected on this official transcript are segmented according to the specified student career.

Student Career designates the type of credit awarded and is assigned on the basis of the student's academic status and level of coursework. A complete program list can be found at *registrar.ku.edu/transcript-key*

A program is the school in which the student is pursuing a degree. Programs are listed on our website at *registrar.ku.edu/transcript-key*

A plan is equivalent to a major, and **a sub plan** is a concentrated study of the plan.

Transfer Work: Transfer credit hours are added to the "earned" hours of the first effective semester. If the transfer work was completed prior to entry at the University of Kansas, it will be reflected during the first in-residence semester. University of Kansas transcripts will reflect only hours accepted from other institutions. Semesters, courses, GPA, and grades from other institutions will not appear on the official University of Kansas transcript.

Test Credits: Test credits are awarded when a student chooses to test out of a given course by taking a proficiency exam. Test credits do not count toward resident credit.

Repeated Courses: If the repeated courses were taken prior to Fall 2001, both courses count toward the GPA. If courses were taken Fall 2001 and after, and meet policy requirements, the first course will not count toward the GPA. (*registrar.ku.edu/transcript-key)*

Distinction and **Highest Distinction** are scholastic honors awarded at the time of graduation by the student's college or school. No more than 10% of the class may receive such honors.

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D	1.0	1.0
D-	0.7	
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Revised: 07/26/2017

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University of Kansas
Lawrence, KS

Official KU Academic Record
Name: Ruth Lehman Wiens
Student ID: 2283039

[redacted]

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OCT 22 2018
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Tiffany Robinson
University Registrar

RAISED SEAL NOT REQUIRED

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The University of Kansas

Office of the University Registrar
KU Visitor Center, 1502 Iowa Street
Lawrence, KS 66045-7576
(785) 864-4423

KEY TO TRANSCRIPT OF ACADEMIC RECORDS

Campus Locations:
University of Kansas - Lawrence
Main, Edwards & West Campus
KU Visitor Center, 1502 Iowa Street
Lawrence, KS 66045-7576
(785) 864-4423

University of Kansas - Medical Center
3901 Rainbow Blvd.
Mail Stop 4029
Kansas City, KS 66160
(913) 588-1048

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University of Kansas

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[redacted]

CONFIDENTIAL

OCT 22 2018

KSBHA

Tiffany Robinson

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The University of Kansas

By the authority of the Board of Regents of the State of Kansas
and upon the recommendation of the faculty of the

SCHOOL OF MEDICINE

confers upon

Ruth Mary Lehman Wiens

the degree of

DOCTOR OF MEDICINE

with all its rights, privileges, and responsibilities.
Given under the seal of the University of Kansas this
fourteenth day of May, two thousand and seventeen.

Bernadette Gray-Little
Chancellor

Bill F. Nunt
Chair, Kansas Board of Regents

SEALED VERIFIED KSBHA

Marla J. Herron
Campus Registrar
October 16, 2018

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OCT 22 2018
KSBHA

I certify this to be a true and accurate copy of the original diploma awarded to Ruth Mary Lehman Wiens for the Doctor of Medicine degree by The University of Kansas on May 14, 2017.

THE UNIVERSITY OF KANSAS
Medical Center

Office of the Registrar
Mail Stop 4005, 3901 Rainbow Blvd.
Kansas City, KS 66160

Address Service Requested

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66612-124473


Maria J Herron

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

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

Applicant:

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

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

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

Copy this form for multiple training programs.

RECEIVED
OCT 15 2018
KSBHA

Section 1: Applicant Information

Last name: Lehman Wiens Suffix: _____

First name: Ruth

Middle name: Mary

Name if different when diploma awarded: _____

Name of postgraduate training program: Wesley Family Medicine Residency

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

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

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

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

Applicant signature: _____ Date: 9/19/18

Dean or Designated Official:

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

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

Make copies and attach additional pages if necessary.

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

Section 2: Postgraduate Training Verification

Institution name: Wesley Family Medicine Residency Program
Institution address: 850 N. Hillside
Institution city / state or province / zip code: Wichita, Kansas 67214
Affiliated medical school name: University of Kansas School of Medicine-Wichita
Institution / school name if different when the applicant attended: _____

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

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7-1-2017 to 6-30-2018

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

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

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

Applicant Name: Ruth Lehman Wiens.

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

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7-1-2018 to 6-30-2019

Successfully completed*? ☐ Yes ☐ No ☒ In progress with expected completion date of 6-30-2019

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

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

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7-1-2019 to 6-30-2020

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

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

Unusual Circumstances

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

Seal Verified KSBHA

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

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Signature: _____
Print name: Gretchen Irwin, MD
Title: Program Director
Date: 10-8-2018
Phone number: 316-962-3976 Fax number: 316-962-7184
Email: gretchen.dickson@wesleymc.com

KU SCHOOL OF MEDICINE WICHITA
The University of Kansas

Division of Graduate Medical Education
1010 N. Kansas
Wichita, KS 67214

Address Service Requested

RETURN SERVICE REQUESTED

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

RECEIVED
OCT 15 2018
KSBHA

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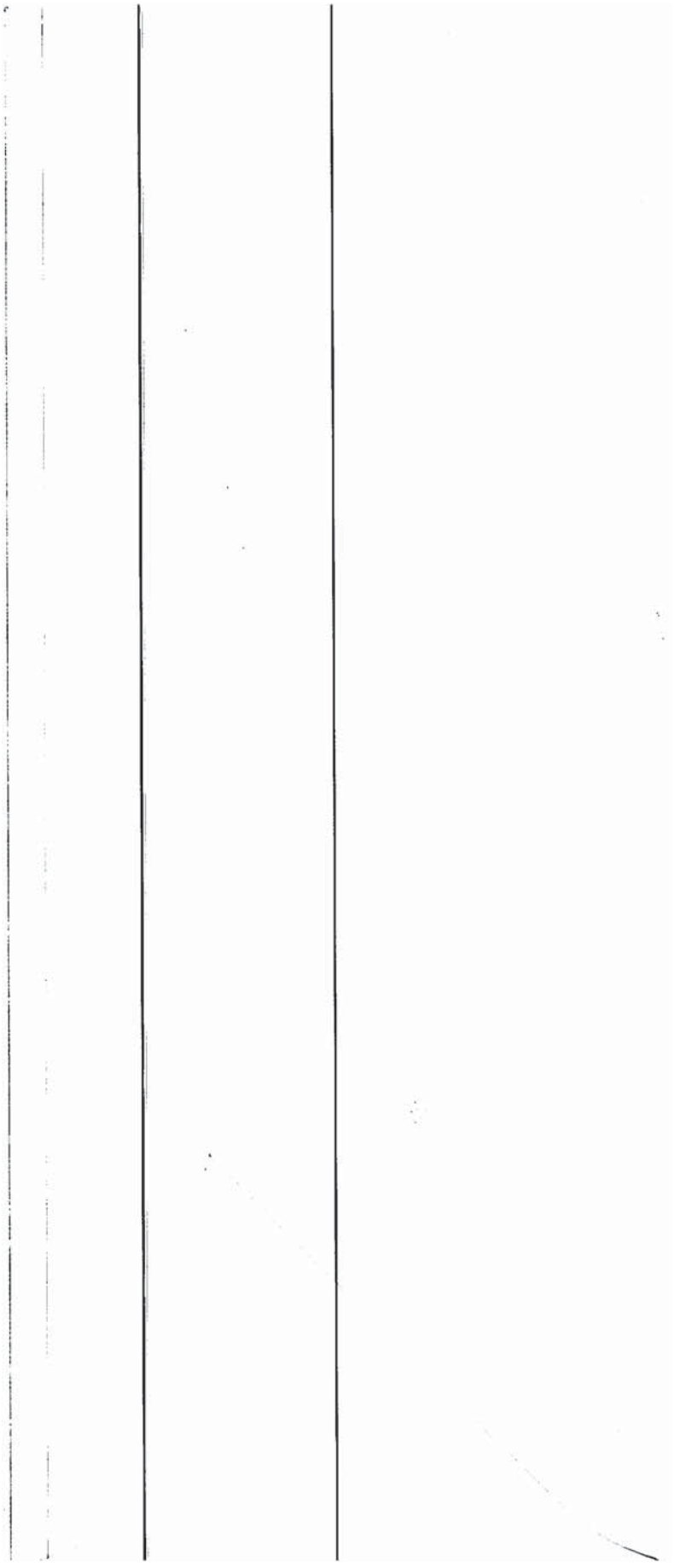

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

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

Recipient: KANSAS STATE BOARD OF HEALING ARTS

Date: 09/20/2018

Examinee: Lehman Wiens, Ruth Mary
Alt Name(s): Wiens, Ruth

Examinee ID: 5-341-908-1
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
05/08/2015	Pass	[redacted]	(192)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/21/2016	Pass	[redacted]	(209)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
07/27/2016	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/25/2018	Pass	[redacted]	(196)	

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®)
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This document was prepared by
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Examinee: Lehman Wiens, Ruth Mary

Examinee ID: 5-341-908-1
Date of Birth: CONFIDE
NTIAL

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.

- Kansas.gov (http://www.kansas.gov)
- State Phone Directory (http://www.da.ks.gov/phonebook/)
- Online Services (http://www.kansas.gov/services/)

KSBHA Licensee & Registrant Profile Search

- Home (/ssrv-ksbhada/search.html)
- KSBHA Web site (http://www.ksbha.org)
- Contact Information (/ssrv-ksbhada/contact.html)
- Help (/ssrv-ksbhada/help.html)

Detailed Search Results

Student/Postgraduate License (/ssrv-ksbhada/help.html#studentLicense)**Profile for Ruth M. Lehman Wiens**

Personal Information

Profession: POSTGRADUATE MD/DO

Address:
WCGME
1010 N Kansas
Wichita, KS, 67210

Phone:
Fax:

Year of Birth: [redacted]

- **School Name:** UNIVERSITY OF KANSAS
- **Degree Date:** 05/14/2017

License Information

- **License Number:** 94-09239
- **License Type:** Active
- **License Status:** Current
- **License Expiration Date:** 06/30/2020
- **Original License Date:** 07/01/2017
- **Last Renewal Date:**
- **Date This Status:** 07/01/2017
- **Continuing Education Year:**
- **Temporary License Permit Number:**
- **Temporary License Permit Issue Date:**

- **Temporary License Permit Expiration Date:**

Practice Specialty

Specialties and board certifications are for MDs and DOs only and are self-reported. Therefore, they are not independently verified by the Board of Healing Arts.

- **Family Medicine**

Other KSBHA Licenses

None Reported

KSBHA Actions

None Reported

Health Care Facility Privilege Actions

None Reported

Other Public License Actions, DEA Actions, Criminal Actions, or Miscellaneous Information

None Reported

Statement from Licensee or Registrant

None Reported

Perform Another Search | Return to Search Results

License Profile last updated: October 17, 2018

- Contact Information (/ssrv-ksbhada/contact.html)
- Disclaimer (/ssrv-ksbhada/disclaimer.html)
- Feedback (http://ksgovernment.feedbacksurvey.sgizmo.com/?website=KSBHA Licensee Search)

- About Us (http://www.kansas.gov/about/)
- Site Map (http://www.kansas.gov/sitemap/)

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)

Lehman Wiens
Applicant's printed last name

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

9/19/18
Date of signature (must correspond to date of notarization)

fold — fold up

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

Notary

State of Kansas, County of Sedgwick,

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 19th day of September, 2018.

Notary Public Signature: Kara Visokey

My Notary Commission Expires: 10/29/19

(NOTARY PUBLIC SEAL)
KARA VISOKEY
NOTARY PUBLIC
STATE OF KANSAS
My Appt. Exp. 10/29/19

ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

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

☒ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

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

List intended professional activities: _____

Additional Information and Statement of Health:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☒ No
2. Give location of intended practice in Kansas Wichita + rural communities
3. Primary Specialty Family Medicine

   American Board Certified no American Board Eligible no
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.

ADDENDUM 2
KANSAS STATE BOARD OF HEALING ARTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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?

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): Ruth Lehman Wiens **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. Lehman Wiens (type or print) for 1+ 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. Lehman Wiens is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Stephanie Murray

Profession: Please select one: MD ☑ DO ☐

Street 1: [redacted]

Street 2:

State/Zip:

Telephone:

Signature:

Date: 10/1/18

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): Ruth Lehman-Wiens **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. Lehman-Wiens (type or print) for 1.5 years; that he/she is a capable physician and is not addicted to alcohol or drugs.

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

(Please type or print)

Name: Erika Burke

Profession: Please select one: MD ☒ DO ☐

Street 1: [redacted]

Street 2:

State/Zip:

Telephone:

Signature:

Date: 8/15/18

[redacted]

WICHITA
KS 670
16 AUG '18
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Kansas State Board of Healing Arts
800 SW Jackson
Lower Level Suite A
Topeka, KS 66612

AUG 20 2018

66612-128967

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AUG 2 0 2018

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): Ruth Lehman Wiens **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. Ruth Lehman Wiens (type or print) for 1 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. Wiens is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Robin A Walker

Profession: Please select one: MD☒ DO☐

Street 1: [redacted]

Street 2:

State/Zip:

Telephone:

Signature: [signature] MD

Date: 8/15/18

[redacted]

WICHITA
KS 670
16 AUG '18
PM 1 L

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

AUG 20 2018

66612-123199

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Kansas State Board of Healing Arts	As of Date:10/22/2018

PRACTITIONER INFORMATION

Name:	Lehman Wiens, Ruth Mary
Alternate Name(s):	Wiens, Ruth
DOB:	[redacted]
Medical School:	University Of Kansas School Of Medicine Wichita Wichita, Kansas, UNITED STATES
Year of Grad:	2017
Degree Type:	MD
NPI:	1861921611

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
KANSAS	94-09239	07/01/2017	06/30/2020	10/02/2018

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Kansas State Board of Healing Arts	As of Date:10/22/2018
Practitioner Name:	Lehman Wiens, Ruth Mary	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

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

AMA Physician Profile

PREPARED FOR

Kansas State Board of Healing Arts, Topeka, KS

Name and Mailing Address

RUTH WIENS

[redacted]

Birth date [redacted]

Primary Office Address

Phone UNKNOWN

Physician's major professional activity HOSPITAL BASED RESIDENTS - ALL YEARS

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 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
None Reported					

Current and/or historical medical school

UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

Degree Awarded: YES
Degree Year: 2017

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: UNIVERSITY OF KANSAS SCHOOL OF MEDICINE (WICHITA)
Sponsoring State: KANSAS
Program name: UNIVERSITY OF KANSAS (WICHITA)/WESLEY PROGRAM
Specialty: FAMILY MEDICINE
Training Type: SPECIALTY
Dates: 7/2017 - 6/2020 (Verified)

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

Specialty Board Certification

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

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

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

Certificate type:

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

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

Current and/or historical medical licensure

License No. MD / DO	Jurisdiction	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported

NONE REPORTED TO DATE

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

None Reported

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.

NAT ONAL PRACT T ONER DATA BANK

NPDB

P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

DCN: 5500000139910701
Process Date: 10/18/2018

LEHMAN WIENS, RUTH MARY
For authorized use by:
KANSAS STATE BOARD OF HEALING ARTS

[redacted] CONFIDENTIAL [redacted]

[redacted]

Receipt Number	Amount	Payer Name	Manual Receipt No/Licencee	Payment Type	
567875	300.00	Lehman Wiens, Ruth Mary		Visa\Mastercard License Fee	Credit Card
567876	47.00	Lehman Wiens, Ruth Mary		Visa\Mastercard KBI	Credit Card
567877	3.00	Lehman Wiens, Ruth Mary		Visa\Mastercard NPDB	Credit Card

Fingerprints in Cabinet

Entered/Receipted Date:
10/15/2018

Refered to Licensing Date:
10/15/2018

Additional Notes:

Receipted By: Andrea Anderson

LIC FER, KBI FEE,NPDB FEE-MD

The University of Kansas

By the authority of the Board of Regents of the State of Kansas
and upon the recommendation of the Faculty of the

SCHOOL OF MEDICINE

confers upon

Ruth Mary Lehman Wiens

the degree of

DOCTOR OF MEDICINE

with all its rights, privileges, and responsibilities.
Given under the seal of the University of Kansas this
fourteenth day of May, two thousand and seventeen.

Bernadette Gray-Little
Chancellor

Bill F. Nunt
Chair, Kansas Board of Regents

I CERTIFY THIS IS
A TRUE AND ACCURATE
COPY OF THE ORIGINAL

KARA VISOKEY
NOTARY PUBLIC
STATE OF KANSAS
My Appt. Exp. 10/29/19

Kara Visokey

Seal Verified KSBHA

RECEIVED
OCT 15 2018
KSBHA

RECEIVED
OCT 15 2018
KSBHA

Applicant Name: Ruth Lehman Wiens

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: _____ License number: _____ Issue date: _____

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

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☐ 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) _____

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Applicant Name: Ruth Lehman Wiens

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.

Addendum 5

Kansas

INSTRUCTIONS FOR REQUESTING A CRIMINAL BACKGROUND CHECK

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

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

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

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

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

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

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

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

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

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

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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

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

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

FBI PRIVACY ACT STATEMENT

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

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

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

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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

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

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

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

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

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

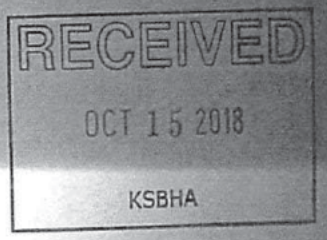
If a change is made to your Kansas criminal history record due to a challenge, a new copy of your Kansas criminal history record will be sent to the Authorized Recipient to make a final decision about your status as an employee, volunteer or contractor, or your eligibility for any pertinent license,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

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

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

[redacted]

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



UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

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

Applicant:

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

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

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

Copy this form for multiple training programs.

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OCT 0 8 2018
KSBHA

Section 1: Applicant Information

Last name: Lehman Wiens Suffix: _____

First name: Ruth

Middle name: Mary

Name if different when diploma awarded: _____

Name of postgraduate training program: Wesley Family Medicine

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

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

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

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

Applicant signature: _____ Date: 10/1/18

Dean or Designated Official:

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

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

Make copies and attach additional pages if necessary.

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

Section 2: Postgraduate Training Verification

Institution name: Wesley Family Medicine Residency Program

Institution address: 850 N. Hillside

Institution city / state or province / zip code: Wichita, KS 67214

Affiliated medical school name: University of Kansas School of Medicine-Wichita

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

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

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7-1-2017 to 6-30-2018

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

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

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

Applicant Name: _____

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

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7-1-2018 to 6-30-2019

Successfully completed*? ☐ Yes ☐ No ☑ In progress with expected completion date of 6-30-2019

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

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

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

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7-1-2019 to 6-30-2020

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

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

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

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OCT 0 8 2018
KSBHA

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

Unusual Circumstances

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

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

SEALED VERIFIED KSBHA

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Signature: _____
Print name: Gretchen Irwin, MD
Title: Program Director
Date: 10-1-2018
Phone number: 316-962-3976 Fax number: 316-962-7184
Email: gretchen.dickson@wesleymc.com

Addendum 5

Kansas

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

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revised 5/4/18 bv

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AND
FBI PRIVACY ACT STATEMENT

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

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

WAIVER AGREEMENT
AND
FBI PRIVACY ACT STATEMENT (Cont.)

Fingerprint-Based Record Checks for Noncriminal Justice Purposes

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

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

RIGHT TO OBTAIN AND CHALLENGE ACCURACY OF CRIMINAL HISTORY RECORDS

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

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

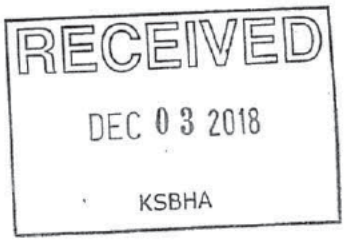
Kansas Bureau of Investigation
Attn: Criminal History Records
1620 SW Tyler
Topeka, Kansas 66612-1837

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

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

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

[redacted]



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