1/29/98

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934

REQUEST FOR APPLICATION FORMS
MEDICAL OR OSTEOPATHIC

PLEASE TYPE OR PRINT CLEARLY

Check one: ☑ I am ☐ I am not applying for Step 3 of the USMLE in May 1998 (Fill in year) December _____ (Fill in year)

The following information must be completed by **ALL** applicants, whether or not you are applying to take the USMLE for Ohio.

PERSONAL INFORMATION

NAME:	LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
	REIDER	MITCHELL	WILLIAM	MD

ADDRESS:	NUMBER & STREET			
	1899 LAWNWAY ROAD			
	CITY	STATE	ZIP CODE	COUNTRY
	SOUTH EUCLID	Ohio	44121	USA

TELEPHONE: BUSINESS: AREA CODE & NUMBER (216) 844-1000 HOME: AREA CODE & NUMBER (216) 381-8625

BIRTH DATE: MO/DAY/YR 01/21/70 BIRTH PLACE: CITY CLEVELAND STATE OHIO COUNTRY USA

MEDICAL OR OSTEOPATHIC EDUCATION

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:	SCHOOL NAME		
	CASE WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE		
	STREET ADDRESS		
	10900 EUCLID AVENUE		
	CITY	STATE	COUNTRY
	CLEVELAND	OHIO	USA

DATES ATTENDED: FROM: MO/YR 09/93 TO: MO/YR 05/97

DEGREE RECEIVED: M.D. DATE RECEIVED: MO/DAY/YR 05/18/97

STATE MEDICAL BOARD 98 JAN 26 PM 3:53

OVER ⇨

OTHER MEDICAL OR OSTEOPATHIC SCHOOLS ATTENDED **(IF NONE, ENTER "NONE"):**

SCHOOL NAME		
NONE		
STREET ADDRESS		
CITY	STATE	COUNTRY

DATES ATTENDED: FROM: MO/YR / TO: MO/YR /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

SCHOOL NAME		
NONE		
STREET ADDRESS		
CITY	STATE	COUNTRY

DATES ATTENDED: FROM: MO/YR / TO: MO/YR /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

FIFTH PATHWAY PROGRAM

FIFTH PATHWAY PROGRAM **(IF NONE, ENTER "NONE"):**

AFFILIATED WITH:

HOSPITAL OR INSTITUTION	
NONE	
NAME OF MEDICAL SCHOOL	
CITY	STATE

DATES ATTENDED: FROM: MO/YR / TO: MO/YR /

QUALIFYING EXAM TAKEN: DATE TAKEN: MO/YR /

CONTINUED ⇨

GRADUATE MEDICAL EDUCATION

List **ALL** graduate medical education (internship, residency or clinical fellowship), undertaken in the U.S. or Canada. If additional space is needed, attach an extra sheet. **(If none, enter "NONE")**

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	Level of Training (check one only)
6 97	UNIVERSITY HOSPITALS OF CLEVELAND (CASE WESTERN RESERVE UNIVERSITY)	PGY-1 OB/GYN	☑ 1st year
TO	11100 EUCLID AVENUE CLEVELAND, OHIO 44106		☐ 2nd year
6 01	11100 EUCLID AVENUE		☐ 3rd year or above
month/year	City CLEVELAND State/Country OHIO (USA) Zip 44106		
	NONE		☐ 1st year ☐ 2nd year ☐ 3rd year or above
TO			
month/year	City State/Country Zip		
	NONE		☐ 1st year ☐ 2nd year ☐ 3rd year or above
TO			
month/year	City State/Country Zip		
	NONE		☐ 1st year ☐ 2nd year ☐ 3rd year or above
TO			
month/year	City State/Country Zip		

OVER ⇨

WRITTEN EXAMINATIONS TAKEN

List each and every written exam (FLEX, National Boards, USMLE, State Board, LMCC) taken, whether in Ohio or any other state, territory or province. Use one section for each exam portion taken. If additional space is needed, attach an extra sheet.

STATE/PROVINCE	DATE TAKEN	TYPE OF EXAM	SECTIONS TAKEN	FINAL RESULTS
OHIO (CASE WESTERN RESERVE UNIV) CLEVELAND OHIO	(MO/YR) 06/95	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☐National Boards ☒USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☐3 Step ☒1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☒PASS ☐FAIL
OHIO (CASE WESTERN RESERVE UNIV) CLEVELAND OHIO	(MO/YR) 08/96	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☐National Boards ☒USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☐3 Step ☐1 ☒2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☒PASS ☐FAIL
	(MO/YR)	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☐National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☐3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☐PASS ☐FAIL
	(MO/YR)	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☐National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☐3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☐PASS ☐FAIL
	(MO/YR)	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☐National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☐3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☐PASS ☐FAIL
	(MO/YR)	(✓ ONE ONLY) ☐FLEX (PRE-1985) ☐FLEX (1985-1994) ☐National Boards ☐USMLE ☐State Board ☐LMCC	(✓ ONE ONLY) ☐Partial ☐Full Component ☐I ☐II Part ☐1 ☐2 ☐3 Step ☐1 ☐2 ☐3 ☐Partial ☐Full ☐Partial ☐Full	(✓ ONE ONLY) ☐PASS ☐FAIL

CONTINUED ⇨

LICENSES IN THE UNITED STATES & CANADA

List ALL states/provinces, **whether the license is current or not**, in which you are or have been licensed (except temporary, educational permits) to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number, date of issuance and the basis of licensure. If additional space is needed, attach an extra sheet. **(If none, enter "NONE")**

STATE/PROVINCE	ISSUE DATE	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
NONE	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
NONE	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
NONE	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
NONE	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
NONE	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
NONE	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
NONE	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
NONE	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______
NONE	(MO/YR)		(✓ ONE ONLY) ☐National Boards ☐FLEX ☐State Board exam ☐USMLE ☐LMCC ☐Other: ______	(✓ ONE ONLY) ☐YES ☐NO Expiration Date: ______

OVER ⇨

ADDITIONAL ELIGIBILITY INFORMATION FOR GRADUATES OF NON ACCREDITED LCME/AOA SCHOOLS

ANSWER ALL QUESTIONS	YES	NO
Do you have a valid ECFMG Certificate? Number: _____ Date Issued: ___/___ MO/YR	☐	☒
Have you held a current and unrestricted license in the U.S. for **at least five years or more**? *(Refer to the TSE section in the Eligibility Packet for more information)*	☐	☒
Have you been actively practicing medicine and surgery or osteopathic medicine and surgery (approved training included) in the U.S. for **at least five years or more**? *(Refer to the TSE section in the Eligibility Packet for more information)*	☐	☒
Have you applied for or taken the Test of Spoken English (TSE*) of the Educational Testing Service (ETS)? Date Taken: ___/___ MO/YR Score: _____	☐	☒

***THE TOEFL, ECFMG EXAM, ETC. ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (TSE)**

FEDERATION CREDENTIALS VERIFICATION SERVICE

	YES	NO
Have you completed and forwarded the FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) application packet to FCVS?	☐	☒

If yes, date forwarded: _____

CERTIFICATION

I hereby certify that I am the person referred to in the foregoing Request for Application forms and that the statements herein are strictly true in every respect.

Mitchell W. Zeidler MD
Signature of Applicant

1/21/98
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934

98 FEB 18 PM 5:43

FOR BOARD USE ONLY
BK: 4 ☐ 34 ☒ 35 PG: 20 LN: 99
DATE: 2/19/98 FEE: $35.00 PMT: ✓

#1541

APPLICATION FOR EXAMINATION - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: Redacted

2. Full Name (Use no initials): LAST (Surname) REIDER | FIRST MITCHELL | MIDDLE WILLIAM | SUFFIX (Jr., II)

3. Name (As you prefer it inscribed on your Ohio license): LAST (Surname) REIDER | FIRST MITCHELL | MIDDLE WILLIAM | SUFFIX (Jr., II)

4. Maiden Name Or Other Names Used (If none, enter "NONE"): LAST (Surname) NONE | FIRST | MIDDLE | SUFFIX (Jr., II)

5. Current Address: STREET & NUMBER 1899 LAWNWAY ROAD
CITY SOUTH EUCLID | STATE OHIO | ZIP CODE 44121 | COUNTRY USA

6. Physical Description: HEIGHT 5'6 | WEIGHT 150 | HAIR COLOR BROWN | EYE COLOR HAZEL | IDENTIFYING MARKS

7. Sex: ☒ MALE ☐ FEMALE For statistics only (optional)

8. City In Ohio Where You Plan To Practice: CITY CLEVELAND, OHIO OR COUNTY CUYAHOGA
PLANS OF PRACTICE: OB-GYN

9. Specialty Boards (U.S.A., Canada and foreign countries):

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
NONE	☐	☐		
	☐	☐		
	☐	☐		

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order from the date of medical school graduation to the PRESENT time, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", as well as your permanent address.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did "locum tenens", you must list all hospitals where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets.

		Hospital, University or Other:	Position & Department	% Clinical
A	06 / 97 month/year TO 02 / 98 month/year	UNIVERSITY HOSPITALS OF CLEVELAND	OB-GYN PGY-1	100
		Complete Street Address: 11100 EUCLID AVENUE Number & Street		% Admin. 0
		CLEVELAND, OHIO 44106 (USA) City State/Country Zip Code		
B	month/year TO month/year	Hospital, University or Other:	Position & Department	% Clinical
		Complete Street Address: Number & Street		% Admin.
		City State/Country Zip Code		
C	month/year TO month/year	Hospital, University or Other:	Position & Department	% Clinical
		Complete Street Address: Number & Street		% Admin.
		City State/Country Zip Code		
D	month/year TO month/year	Hospital, University or Other:	Position & Department	% Clinical
		Complete Street Address: Number & Street		% Admin.
		City State/Country Zip Code		

OVER ⇨

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

E	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City State/Country Zip Code	Position & Department	% Clinical % Admin.
F	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City State/Country Zip Code	Position & Department	% Clinical % Admin.
G	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City State/Country Zip Code	Position & Department	% Clinical % Admin.
H	month/year TO month/year	Hospital, University or Other: Complete Street Address: Number & Street City State/Country Zip Code	Position & Department	% Clinical % Admin.

CONTINUED ⇨

STATE MEDICAL BOARD
OHIO
98 FEB 18 PM 5:43

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☒
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☒
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☒
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, or graduate medical education?	☐	☒
5.	Have you ever transferred from one graduate medical education to another?	☐	☒
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☒
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☒

OVER ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

		YES	NO
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☒
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☒
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☒
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☒
12.	Have you ever been notified of any investigation concerning you by, or have you ever been notified of, any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	Are you now or have you ever been, addicted to or excessively used alcohol, drugs, or other substances which may cause physical or psychological dependence, or impairment of the ability to practice?	☐	☒
14.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☒
15.	Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☒

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

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		YES	NO
16.	Have you ever been denied, or surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☒
17.	Have you ever been convicted or found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	☐	☒
18.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☒
19.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☒
20.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage cancelled, limited, or restricted in any way?	☐	☒
21.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☒
22.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☒

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934

98 FEB 18 PM 5:43

Applicant Circle one: (May) or December 1998 examination
(fill in year)

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physician are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Nancy Judy, a licensed and practicing physician in the state of
(recommending physician)

OHIO, affirm that MITCHELL WILLIAM REIDER
(state of residence) (applicant)

has been known to me personally for 1 years and that he/she is of good moral character.

Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application to take the examination:

*I rate his/her medical knowledge and technique as: Excellent

*His/her relationship with patients is: professional + appropriate

*I rate his/her ability to work well with peers and medical staff as: outstanding

*His/her command of the English language is: flawless

*Additional comments: _____

I hereby recommend him/her to sit for the examination in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

Signature of Recommending Physician
(name stamps not acceptable)

NANCY JUDGE, MD
Name of Recommending Physician
(please type or print clearly)

(216) 844 3593
Telephone Number
(include area code)

11000 EUCLID, CLEVELAND OH 44106
Address of Recommending Physician
(include city, state and zip code)

Ohio 35-04-3328
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

Subscribed and sworn to before me this 12 day of FEB, 1998.

Notary Public Signature

JULY 8, 1998
Date Commission Expires

Mitchell D. Reidel MD
Signature of Applicant

Date Photo Taken: 01/98
Mo/Yr

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 10/21/96

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934

Applicant Circle one: (May) or December 1998 (fill in year) examination

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physician are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, LASZLO SOGOR (recommending physician), a licensed and practicing physician in the state of OHIO (state of residence), affirm that MITCHELL WILLIAM REIDER (applicant) has been known to me personally for 2 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application to take the examination:

98 FEB 6 PM 4:16 STATE MEDICAL BOARD OHIO

*I rate his/her medical knowledge and technique as: excellent

*His/her relationship with patients is: excellent

*I rate his/her ability to work well with peers and medical staff as: excellent

*His/her command of the English language is: excellent

*Additional comments: _____

I hereby recommend him/her to sit for the examination in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

Signature of Recommending Physician
(name stamps not acceptable)

LASZLO SOGOR, MD
Name of Recommending Physician
(please type or print clearly)

(216) 844-1000
Telephone Number
(include area code)

11100 EUCLID AVENUE
Address of Recommending Physician
(include city, state and zip code)
CLEVELAND, OHIO 44106

OHIO 34-04-4396
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

Subscribed and sworn to before me this 12 day of FEB., 1998

Notary Public Signature

JULY 8, 1998
Date Commission Expires

Mitchell W. Reider MD
Signature of Applicant

Date Photo Taken: 01/98
Mo/Yr

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 10/21/96

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43266-0315 • (614) 466-3934 • Website: www.state.oh.us/med/

DATE: 3/17/98

Univ Hosp-Cleveland

Dear Doctor:

Dr. Mitchell W. Reider, MD who is/was Resident OB/GYN 7/97 - PRESENT is applying to sit for Step 3 of the USMLE in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for the examination. ***To ensure processing of the physicians application please complete this form and return to the Ohio State Medical Board within two (2) weeks by either mail or FAX.*** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Information provided is considered confidential under Section 149.42 (A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known him/her? _____

(2) What is/was your supervisory capacity? _____

(3) At what hospital? _____

(4) How would you rate his/her medical knowledge and techniques? _____

(5) In your opinion is he/she a person of good moral and ethical character? _____

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

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

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

(9) Would you recommend him/her to take the examination? _____

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

_____

_____

Sincerely,

Penny E. Grubb

Penny E. Grubb
Chief, Licensure

_____
Signature of Physician

_____
Name of Physician (please type or print clearly)

_____
Position

_____
Telephone number (include area code)

Direct Dial: (614) 466-9234
FAX: (614) 466-4670
Website: www.state.oh.us/med/
E-Mail Address: med_grubbp@ohio.gov

AFFIDAVIT AND RELEASE OF APPLICANT

STATE MEDICAL BOARD

The affidavit and release below MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

98 FEB 18 PM 5:45

ss STATE OF: OHIO
COUNTY OF: CUYAHOGA

I, MITCHELL WILLIAM REIDER, hereby certify under oath that I am the person named in this application to take the examination in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

I further state that by filing this application to take the examination in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to sit for the examination. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application to take the examination in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to admission to the examination being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request to take the examination and that any fee I submitted is not refundable nor transferable.

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

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that admittance to the examination in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said examination.

Mitchell W. Reider MD
Signature of Applicant

Subscribed and sworn to before me this 12 day of FEB 1998

Renee Richardson
Signature of Notary Public

(NOTARY SEAL)

Jul 8, 1998
Date Commission Expires

Revised 10/21/96

FOR BOARD USE ONLY

NAME: Mitchell William Reiley, MD

CERTIFICATE NO.: _____

DATE ISSUED: _____, 199____

APPLICATION FOR EXAMINATION
MEDICINE OR OSTEOPATHIC MEDICINE

FILED: January 29, 1998

DETERMINATION:

BOARD ACTION:

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

20-28-39
#1700
#300.00
5-24-99

APPLICATION FOR CERTIFICATE ISSUANCE FOLLOWING EXAMINATION
MEDICINE OR OSTEOPATHIC MEDICINE

OHIO STATE MEDICAL BOARD
MAY 18 1999

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: Redacted

2. Full Name (Use no initials):

Last (Surname)	First	Middle	Suffix (Jr., II)
REIDER	MITCHELL	WILLIAM	

3. Name (As you prefer it inscribed on your Ohio license):

Last (Surname)	First	Middle	Suffix (Jr., II)
REIDER	MITCHELL	WILLIAM	

4. Current Address:

Number & Street: 1899 LAWNWAY ROAD

City	State	Zip Code	Country
SOUTH EUCLID	OHIO	44121	USA

5. Telephone Number:

Work: Area Code & Number (216) 844-8551

Home: Area Code & Number (216) 381-8625

6. City in Ohio Where You Plan to Practice (If known):

City CLEVELAND, OHIO or County CUYAHOGA (USA)

Plans of Practice (If known): PGY 3, PGY 4 OB/GYN RES

CONTINUED ⇨

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below MUST be completed by ALL applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

OHIO STATE MEDICAL BOARD

MAY 18 1999

ss STATE OF OHIO
COUNTY OF CUYAHOGA

I, MITCHELL WILLIAM REIDER, hereby certify under oath that I am the person named in this application for a certificate to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that any fee I submit is not refundable nor transferable.

I further state that by filing this application for said certificate in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for a certificate to practice medicine or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for said certificate in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to a certificate being issued. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a certificate to practice medicine or osteopathic medicine and that any fee I submit is not refundable nor transferable.

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

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that said certificate in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

Mitchell W. Reider MD
Signature of Applicant

Subscribed and sworn to before me this day 1ST of May 1999.

Notary Public Signature

(NOTARY SEAL)

Date Commission Expires

M.J. REIDER
Notary Public, State of Ohio
My Commission Expires Aug. 5, 2000

FOR BOARD USE ONLY

NAME:_____

CERTIFICATE NO.:_____

DATE ISSUED:_____, 199_____

APPLICATION FOR CERTIFICATE ISSUANCE FOLLOWING EXAMINATION MEDICINE OR OSTEOPATHIC MEDICINE

FILED:_____, 199_____

DETERMINATION:

BOARD ACTION:

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0313 • 614/ 466-3934 • Website: www.state.oh.us/med/

March 23, 1998

Mitchell William Reider MD
1899 Lawnway Rd.
S. Euclid, OH 44121

Dear Doctor:

Your application for Step 3 of the 5/98 USMLE has been received. However, a review of your application indicates the following has not been received:

1. Your core credentials packet from the Federation Credentials Verification Service (FCVS) has not been received. If you have submitted the application to FCVS you will be notified by them of the status. The Ohio Board requires verification of one year of postgraduate training. Therefore, since you will not be completing your 1st year of training until 6/30/98, the Federation will not be able to forward your FCVS packet until verification has been received from your training program. PLEASE NOTE THAT YOUR TRAINING WILL NOT BE VERIFIED UNTIL AFTER 6/30/98, THEREFORE THIS WILL NOT PROHIBIT YOU FROM TAKING THE USMLE. Once your profile is completed, FCVS will send you an acknowledgment letter that your packet has been forwarded to the Ohio Board. **Do not call FCVS to inquire about the status of your application.**

2. The Physician Profile from the American Medical Association (AMA) has not been received. Profiles are sent directly to Ohio Board within 15 business days after receipt by the AMA. If you have forwarded the profile to the AMA and it has been longer than 30 business days contact the AMA at (312) 464-5199 to inquire about the status of your profile.

Do not contact the Board to inquire about the status of your application or to inform the Board that you have requested the information. Time spent answering telephone inquiries is time lost from processing applications.

Unless you are otherwise notified, we will continue processing your application for the examination. Notification of specific dates, times, and location will be sent at least 30 days prior to the first day of the exam.

BE SURE TO NOTIFY THE BOARD, IN WRITING, OF ANY CHANGE IN ADDRESS.

Sincerely,

Penny E. Grubb

Penny E. Grubb
Chief, Licensure

Direct Dial: (614) 466-9234
FAX: (614) 466-4670
E-Mail Address: med_grubbp@ohio.gov

USMLE
United States
Medical
Licensing
Examination
™

UNITED STATES MEDICAL LICENSING EXAMINATION™

The Federation of State Medical Boards of the U.S., Inc.
400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855
Telephone: (817) 571-2949

OH-2

STEP 3 SCORE REPORT

Reider, Mitchell William

1899 Lawnway Road
South Euclid, OH 44121

USMLE ID: 4-053-648-4

Test Date: May 1998

The USMLE is a single examination program for all applicants for medical licensure in the United States; it replaced the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. **Step 3** is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 3 on the test date shown above.

PASS	This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.

193	This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 205 and 18, respectively, with most scores falling between 140 and 260. A score of 177 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)‡ for this scale is approximately five points.

79	This score is also determined by your overall performance on the examination. A score of 82 on this scale is equivalent to a score of 200 on the scale described above. A score of 75 on this scale, which is equivalent to a score of 177 on the scale described above, is recommended by USMLE to pass Step 3. The SEM‡ for this scale is approximately one and a half points.

‡Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The standard error of measurement (SEM) provides an estimate of the range within which your scores might be expected to vary by chance if you were tested repeatedly using similar tests.

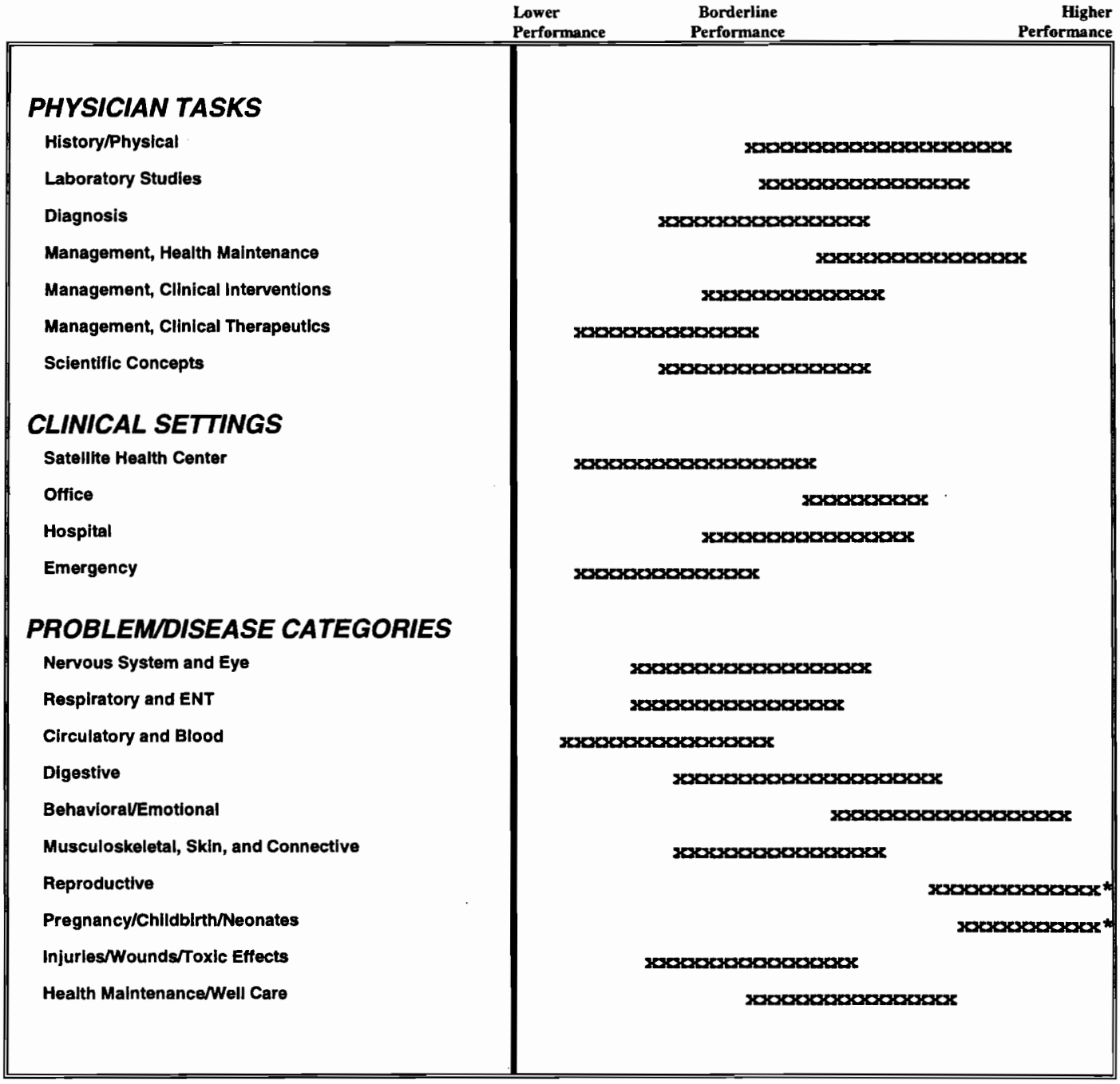
362FS096

NOTE: Original score report has copy-resistant watermark.

INFORMATION PROVIDED FOR EXAMINEE USE ONLY

The Performance Profile below is provided solely for the benefit of the examinee.
These profiles are developed as assessment tools for examinees only and will not be reported or verified to any third party.

USMLE STEP 3 PERFORMANCE PROFILES



The above Performance Profile is provided to aid in self-assessment. The shaded area defines a borderline level of performance for each content area; borderline performance is comparable to HIGH FAIL / LOW PASS on the total test.

Performance bands indicate areas of relative strength and weakness. Some performance bands are wider than others. The width of a performance band reflects the precision of measurement: narrower bands indicate greater precision. The band width for a given content area is the same for all examinees. An asterisk indicates that your performance band extends beyond the displayed portion of the scale. Small differences in the location of bands should not be over interpreted. If two bands overlap, the performance in the associated areas should not be interpreted as significantly different.

Additional information concerning the topics covered in each content area can be found in the *USMLE Step 3 General Instructions, Content Description, and Sample Items.*

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

August 3, 1998

Mitchell William Reider MD
1899 Lawnway Rd.
S. Euclid, OH 44121

Dear Dr. Reider:

We are pleased to inform you that as a result of your recent examination before the State Medical Board of Ohio, you are eligible to apply for a certificate. Your USMLE Step 3 score report is enclosed.

The passing score acceptable to the Board for the USMLE Step 3 will be that figure recommended by the Federation of State Medical Boards (Rule 4731-6-07, Ohio Administrative Code).

However, before a certificate to practice medicine or osteopathic medicine and surgery can be issued you must complete the enclosed Application for Certificate Issuance Following Examination and return it to the Board at the above address, along with the required fee.

As you may well know, instances of cheating have been uncovered in various states relating to past examinations. You should be aware that Section 4731.22(A), Ohio Revised Code, provides that the State Medical Board may revoke a license issued to a person who is found by the Board to have committed fraud in passing the examination. Furthermore, Section 4731.22(A), Ohio Revised Code, requires any licensee to report to the Board information which is believed to indicate a violation of the Medical Practice Act.

Sincerely,

Penny E. Grubb

Penny E. Grubb
Chief, Licensure

PEG/rg

Enclosures:

Direct Dial: (614) 466-9234
FAX: (614) 466-4670

The Federation of State Medical Boards of the U.S., Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3855
Tel: (817) 868–5000
Fax: (817) 868–5099

Physician Information Profile

This report is compiled exclusively for:

Name: **Mitchell William Reider**
SSN: Redacted
DOB: **01/21/1970**
Recipient: **State Medical Board of Ohio**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per a written request made by FCVS. All documents bearing the official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

The Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. The Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board of Directors. **The use of this Physician Information Profile to establish independent data files or compendiums of information is strictly prohibited.**

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Table of Contents

Section I:

FCVS / FSMB Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Mitchell William Reider**	
Other Name Used:	**N/A**	
Gender:	**Male**	
Date of Birth:	**01/21/1970**	
Place of Birth:	**Cleveland, OH**	
SSN:	Redacted	
Current Address:	**1899 Lawnway Road** **South Euclid , OH 44121**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus.:	**(216)844-1000 ext. 31387**
	Fax:	**NA**
	Home:	**(216) 381-8625**
	Other:	**NA**
Physical Description:	Height:	**5' 6"**
	Weight:	**150 lbs**
	Eye Color:	**Hazel**
	Hair Color:	**Brown**
Physical Marks:	Location:	**N/A**
	Description:	**N/A**

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

Institution:	**Miami Univeristy** **Oxford, OH 45056**
Dates of Attendance:	**08/1988 - 05/1992**
Degree Awarded:	**Bachelor of Arts**

Medical Education:

Medical School:	**Case Western Reserve University School Of Medicine** **10900 Euclid Avenue, Room T408** **Cleveland, OH 44106-4920**
Dates of Attendance:	**08/00/1993 - 05/00/1997**
Graduation Date:	**05/18/1997**
Degree Awarded:	**Doctor of Medicine**
Unusual Circumstance:	**Not reported by the Primary Source**

Post Graduate Medical Education:

Institution:	**University Hospitals of Cleveland** **1100 Euclid Avenue/Lakeside 1500** **Cleveland, OH 44106-1655**
Post Graduate Year:	**1**
Program Type:	**Residency**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/1997 - 06/30/1998**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Examination History:

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

Board Action:

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

End of Report for: **Mitchell William Reider**
Packet ID#6325

FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Discrepancy* Report

The following information, as explained below, emerged as discrepant in this physician's profile:

Section of Profile in Question	FCVS Interpretation of Discrepancy	Solution to Discrepancy
Continuity of Education	There is a gap of approximately 1 year between completion of premedical education at Miami University (ends 05/1992) and entrance into medical school at Case Western Reserve University School of Medicine (begins 08/1993).	Left to Board discretion.
Verification of Medical Education Case Western Reserve University School of Medicine	This institution did not complete the Medical Education Form. A standardized letter was provided instead. This form does not include information regarding Unusual Circumstances and Premedical Education.	Left to Board discretion.
Verification of Postgraduate Medical Education University Hospitals of Cleveland	This institution did not indicate the date of the signature in the Certification section of the Postgraduate Medical Education Form. The form was received by FCVS on 08/21/1998.	Left to Board discretion.

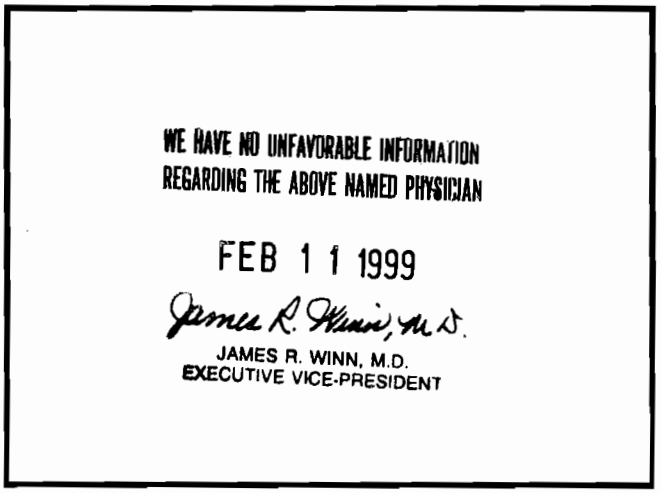
* Please call 1-888-ASK-FCVS if you require documentation of any of the above discrepancies.

FCVS PACKET ID: 0006325

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name:	**Reider, Mitchell William**
Date of Birth:	**01/21/1970**
Medical School:	**036010 - Case Western Reserve Univ**
Year of Graduation:	**1997**
Social Security Number:	Redacted
ECFMG Number:	**N/A**

Results:



Section II:

Identity

AFFIDAVIT AND RELEASE FROM APPLICANT

I, MITCHELL WILLIAM REIDER, MD
(type/print your complete name)

hereby certify under oath that I am the person named in this application, that all statements I have or shall make are true, that I am the 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 I furnish with my application are strictly true.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize every person, hospital, clinic, government agency (local, state, federal or foreign), institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, or true and correct copies of documents or records.

I hereby release, discharge, and hold harmless the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, records, or documents of any and all liability. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Mitchell W. Reider MD 2/12/98
Applicant's Signature (must be signed in the presence of a notary)

REIDER
Applicant's **Printed** Last Name

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

2/10/98, 2/12/98
Date of Signature (must correspond to date of notarization)

(Applicant: Sign your name across either the top or bottom of your photograph.)

State of OHIO, County of CUYAHOGA,
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 12 day of FEB, 19 98.

Notary Public signature: Renee Richardson

My commission expires: JULY 8, 1998

PACKET ID: 0006325

OHIO DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF LIVE BIRTH

Registrar's No. 2059

Birth No. 134 -

1. CHILD — NAME: First: Mitchell; Middle: William; Last: REIDER		2a. DATE OF BIRTH (Month, Day, Year): January 21, 1970	2b. HOUR: 2:18 A
3. SEX: Male	4a. TWIN, TRIPLET, etc.: Single	4b. IF NOT SINGLE BIRTH — Born first, second, third, etc. (Specify):	5. COUNTY OF BIRTH: Cuyahoga
5a. CITY, VILLAGE, OR LOCATION OF BIRTH: Cleveland	5b. INSIDE CITY LIMITS (Specify yes or no): Yes	5d. HOSPITAL—NAME (If not in hospital, give street and number): University Hospitals of Cleveland	
6. MOTHER — MAIDEN NAME: First: Constance; Middle: Terri; Last: Blumenfeld		6b. AGE (At time of this birth): 24	6c. STATE OF BIRTH (If not in U.S.A., name country): Ohio
7a. RESIDENCE — STATE: Ohio	7b. COUNTY: Cuyahoga	7c. CITY, VILLAGE, OR LOCATION: Cleveland	7d. INSIDE CITY LIMITS (Specify yes or no): Yes
			7e. STREET AND NUMBER: 2890 VanAken Boulevard
8. FATHER — NAME: First: Marc; Middle: Joel; Last: Reider		8b. AGE (At time of this birth): 24	8c. STATE OF BIRTH (If not in U.S.A., name country): Ohio
9a. INFORMANT'S NAME OR SIGNATURE: Marc Joel Reider			9b. RELATION TO CHILD: Father
I certify that the above named child was born alive at the place and time and on the date stated above. 10a. SIGNATURE: R. J. Nowak		10c. DATE SIGNED: 1/21/70	10d. ATTENDANT — M.D., D.O., midwife, other (Specify): M. D.
10b. CERTIFIER — NAME (Type or Print): N. J. Nowak, M.D.		10e. MAILING ADDRESS (Street or R.F.D. No., City or Village, State, Zip): 2626 N. Park Blvd.	
11a. REGISTRAR — SIGNATURE: Elden			11b. DATE RECEIVED BY LOCAL REGISTRAR: FEB 13 1970

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY

NOV 4 1998

CERTIFIED COPY

Section III:

Medical Education

RECEIVED JUN 0 9 1998

CASE WESTERN RESERVE UNIVERSITY

School of Medicine
Verification of Enrollment
FICE CODE: 003024

Federation Credentials Verification Service
400 Fuller Wiser Road,Suite 300
Euless,TX 76039-3855

This form is designed to expedite the reporting of pertinent and timely academic information. Thank you for accepting this verification in lieu of completing a form that may have been provided. This document is considered unofficial without the School seal and the signature ot the Registrar.

NAME: Mitchell William Reider, M.D.
(This information must be provided by the requesting agency)

SSN: Redacted
(This information must be provided by the requesting agency)

DOB: 01/21/70
(This information must be provided by the requesting agency)

The above referenced physician was enrolled at Case Western Reserve University School of Medicine,

From 08/93 **To** 05/97

and the Doctor of Medicine (M.D.) degree was awarded on 05/18/97 .

Date of Verification: 06/02/98

SEAL

Byrd Jones, Jr., M.D.A.
Registrar

School of Medicine
Office of the Registrar

MAILING ADDRESS
Case Western Reserve University
10900 Euclid Avenue
Cleveland, Ohio 44106-4920

VISITORS AND DELIVERIES
School of Medicine
2109 Adelbert Road
Room T-408

Phone 216-368-3722
Fax 216-368-4621

"COPY" APPEARS ACROSS FACE OF ENTIRE DOCUMENT WHEN PHOTOCOPIED. LIQUID BLEACH TURNS OFFICIAL PAPER BROWN.

CASE WESTERN RESERVE UNIVERSITY
OFFICE OF THE REGISTRAR • CLEVELAND, OHIO 44106-7042 • PHONE 216-368-4310

TRANSCRIPT GUIDE PRINTED ON BACK

STUDENT ID # Redacted
STUDENT NAME MITCHELL WILLIAM REIDER

CLASSIFICATION: GRADUATE/PROFESSIONAL
ENTRY TERM: FALL 1993

DOCTOR OF MEDICINE AWARDED 05/97
MEDICINE

CWRU CREDIT:

FALL 1993 SCHOOL OF MEDICINE

CAPG C061	CORE ACADEMIC PROGRAM 1ST YR.	9.00
FAMD 4002	MEDICINE "IN THE STREETS":	1.00
EMMD 4002	CLINICAL APPROACHES IN	1.00

TERM HRS ATT 11.00 ERN 11.00 AVG 0.00 PTS 0.00 GPA 0.00

SPRING 1994 SCHOOL OF MEDICINE

CAPG C061	CORE ACADEMIC PROGRAM 1ST YR.	9.00
PEDS 2001	BEHAVIORAL PEDIATRICS RESEARC	1.00
IMMU 3001	THE AIDS EPIDEMIC	1.00
PEDS 5001	CANCER & BLOOD DISEASES IN CH	1.00
FAMD 5010	DX AND RX IN FAMILY PRACTICE	1.00
EMMD 5003	CLINICAL EMERGENCY MEDICINE:	1.00
PEDS 4001	CHILD ABUSE AND NEGLECT	1.00
FAMD 4008	MANAGING STRESS: OUR PATIENT	1.00

TERM HRS ATT 16.00 ERN 16.00 AVG 0.00 PTS 0.00 GPA 0.00

FALL 1994 SCHOOL OF MEDICINE

CAPG C062	CORE ACADEMIC PROGRAM 2ND YEAR	9.00
DERM 3001	THE HISTOLOGY OF SKIN	1.00
PEDS 3005	PROBLEMS OF THE NEWBORN PERIO	1.00
FAMD 4011	WELLNESS FOR MEDICAL STUDENTS	1.00
ORTH 5006	CLINICAL CORRELATION:MSI	1.00

TERM HRS ATT 13.00 ERN 13.00 AVG 0.00 PTS 0.00 GPA 0.00

SPRING 1995 SCHOOL OF MEDICINE

CAPG C062	CORE ACADEMIC PROGRAM 2ND YR.	9.00

TERM HRS ATT 9.00 ERN 9.00 AVG 0.00 PTS 0.00 GPA 0.00

FALL 1995 SCHOOL OF MEDICINE

PEDC 0101	PEDIATRICS AT UH	1.00
PEDC 0101	PEDIATRICS AT UH	1.00
SURC 0701	SURGERY AT MS	1.00
SURC 0701	SURGERY AT MS	1.00
PSYC 0502	PSYCHIATRY AT BVA	1.00
PSYC 0502	PSYCHIATRY AT BVA	1.00

TERM HRS ATT 6.00 ERN 6.00 AVG 0.00 PTS 0.00 GPA 0.00

SPRING 1996 SCHOOL OF MEDICINE

MEDC 0701	MEDICINE AT MS	1.00
MEDC 0701	MEDICINE AT MS	1.00
MEDC 0701	MEDICINE AT MS	1.00
CARE 9901	FAMILY MEDICINE	1.00
OBGC 0101	OB/GYN AT UH	1.00
OBGC 0101	OB/GYN AT UH	1.00

TERM HRS ATT 6.00 ERN 6.00 AVG 0.00 PTS 0.00 GPA 0.00

FALL 1996 SCHOOL OF MEDICINE

NSCI 0701	NEUROLOGY at MTSI	1.00
DERM 0101	DERMATOLOGY	1.00
CLMI 0701	ADVANCED CLINICAL MEDICINE	1.00
RADI 0701	RADIOLOGY	1.00
UNEL 0001	UNLISTED ELECTIVE	1.00

TERM HRS ATT 5.00 ERN 5.00 AVG 0.00 PTS 0.00 GPA 0.00

SPRING 1997 SCHOOL OF MEDICINE

CARE 0103	PRIMARY CARE - USHC	1.00
ETHC 0102	CLINICAL ETHICS	1.00
PULM 0701	PULMONARY MEDICINE	1.00

TERM HRS ATT 3.00 ERN 3.00 AVG 0.00 PTS 0.00 GPA 0.00

* CUM HRS ATT 69.00 ERN 69.00 AVG 0.00 PTS 0.00 GPA 0.00

TOTAL CREDITS EARNED 69.00
*** END DOCUMENT ***

This is a Red Ink Stamp

JUN 0 2 1998

Amy Hammett
UNIVERSITY REGISTRAR

RECIPIENT:

FEDERATION CREDENTIALS SERVICE
FEDERATION PLACE
400 FULLER WISER RD STE 300
EULESS TX 76039-3855

THIS TRANSCRIPT IS PRINTED ON SCRIPSAFE PAPER AND DOES NOT REQUIRE A RAISED SEAL. THE PAPER IS LIGHT BLUE IN COLOR AND THE REGISTRAR'S SIGNATURE IS IN RED.

RECEIVED JUN 0 4 1998

CASE WESTERN RESERVE UNIVERSITY • CLEVELAND OHIO 44106

KEY TO TRANSCRIPT

ACCREDITATION

Case Western Reserve University is fully accredited by the North Central Association of Colleges and Secondary Schools, Commission on Colleges and Universities. In addition, several of its programs are fully accredited by nationally recognized professional accrediting associations.

AUTHENTICATION OF THE RECORD

All official transcripts must bear the University seal, the facsimile of the University Registrar's signature, and be printed on Scrip-Safe paper.

GRADING SYSTEM – MEDICAL SCHOOL

Neither grades nor cumulative Grade Point Average (GPA) are applicable to the School of Medicine.

GRADING SYSTEM – (ALL OTHER SCHOOLS) EFFECTIVE FALL SEMESTER 1987

Cumulative Grade Point Average (GPA) is based on a 4.00 system. Each school has the option to adopt any grade on the grading system. Those grades which are currently reserved for specific schools are so defined. (For questions concerning grades not listed, please contact University Registrar's Office)

Grade	School Definition	Quality Points
A+	(Law School, prior to Fall 1994)	4.33
A	All Schools	4.00
A-	(Law School, Dental School)	3.66
B+	(Law School, Dental School)	3.33
B	All Schools	3.00
B-	(Law School, Dental School)	2.66
C+	(Law School, Dental School)	2.33
C	All Schools	2.00
C-	(Law School, Dental School)	1.66
D+	(Law School, Dental School)	1.33
D	All Schools*	1.00
D-	(Law School, Dental School)	0.66
F	All Schools	0.00

* Not awarded students at the Mandel School of Applied Social Sciences and School of Nursing; considered a poor grade for students in the School of Graduate Studies or any professional school.

THE FOLLOWING GRADES ARE NOT USED IN THE CALCULATION OF THE GPA.

AD	Successful Audit
H	Honor (Law School LL.M. USLS)
H	High Honors in Pass/Fail Course (Nursing School)
I	Incomplete (Undergraduate)
IN	Incomplete (Graduate & Professional Schools)
NG	Unsuccessful Audit (Graduate & Professional Schools)
NP	Not Passing (Pass/No Pass course only)
P	Passing (Pass/No Pass course only). Since Fall 1987, the P is posted for all undergraduates as a result of earning a grade of D or higher. Prior to Fall 1987, posting of the grade P was the result of earning the grade of C or higher for students in Western Reserve College and D or higher for students in Case Institute of Technology.
R	Satisfactory. (For courses that extend more than one semester. Final grade issued at conclusion of course.)
RPT	Indicates the course has been repeated.
S	Satisfactory (Master/Doctoral Thesis).
U	Unsatisfactory. Used in the School of Graduate Studies as punitive through 12/31/90.
W	Withdrew from the class.
WD	Withdrew from all classes.
WF	Withdrawn under Academic Regs. 5 & 6 (Law School)
WU	Withdrew from all classes (prior to 1989).
Z	INSTRUCTOR DID NOT TURN IN GRADE

(NOTE: Prior to the 1987 Fall Semester, the grade of R indicated performance in designated graduate level courses, advanced seminars, thesis and dissertation research. The grades of S or P, on all graduate level courses, replace the R grade.)

ACADEMIC HONORS, ACADEMIC PROBATION, DISMISSAL/ SEPARATION AND OTHER DESIGNATIONS

Each school within the University has a distinctive method for determining which of its students are to receive honors and/or be placed on academic probation or be academically dismissed/separated from the University. These determinations are made by the specific academic policies within each school of the University. Each school places on the transcript the designations it deems pertinent for the semester. Contact the University Registrar's office for specific guidelines.

FRESHMAN POLICY (UNDERGRADUATE SCHOOL ONLY)

Effective with the 1987 Fall Semester, new, first time full-time freshmen are eligible during their first two semesters of enrollment for grade suppression for the grades of F, NP, and W. Full-time status requires enrollment for 12 or more credits. Transfer students who have been enrolled for one semester elsewhere are eligible in their first semester at CWRU, if enrolled full-time. Other transfer students are not eligible.

NUMBERING OF COURSES

100-199	Elementary Courses
200-299	Intermediate Courses
300-399	Advanced Undergrad Courses
400 & Up	Graduate Courses (open to Undergraduates by consent only)

The above numbering system does not apply to the schools of Dentistry, Law, Medicine and Nursing.

TO WHOM IT MAY CONCERN:

THIS IS A TRUE COPY OF THE ACADEMIC RECORD OF THE STUDENT NAMED AND IN COMPLIANCE WITH THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974. THIS INFORMATION IS RELEASED ON THE CONDITION THAT THE RECIPIENT "WILL NOT PERMIT ANY OTHER PARTY TO HAVE ACCESS TO SUCH INFORMATION WITHOUT THE WRITTEN CONSENT OF THE STUDENT".

TO TEST FOR AUTHENTICITY: The face of this document has a blue background and the name of the institution appears in small print. Apply liquid bleach to the sample background printed below. If authentic, the paper will turn brown.

CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE UNIVERSITY • CASE WESTERN RESERVE

ADDITIONAL TEST: When photocopied, the word COPY appears prominently across the face of the entire document. A black and white document is not an original and should not be accepted as an official institutional document. ALTERATION OR FORGERY OF THIS DOCUMENT IS A CRIMINAL OFFENSE! If you have additional questions about this document, please contact the Office of the Registrar at 216-368-4321.

6325

CASE WESTERN RESERVE UNIVERSITY

This is a true certified copy
of the original diploma issued
to Mitchell William Reider, M.D.
on May 18, 1997.

Byrd Jones, Jr., M.B.A.
CWRU School of Medicine
10900 Euclid Avenue
Cleveland, OH 44106-4920

June 2, 1998

On the recommendation of the Faculty of

The School of Medicine

The Trustees of the University have admitted

Mitchell William Reider

to the Degree of

Doctor of Medicine

Given at Cleveland Ohio May eighteenth Nineteen Hundred Ninety Seven

President

Dean

Section IV:

Postgraduate Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

(This form must be completed by the Program Director)

INSTRUCTIONS TO THE PROGRAM DIRECTOR

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your postgraduate training program to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it, together with an official copy of the individual's record (indicating rotations, dates, and hours of training, scores, grades or evaluations), to FCVS in the enclosed postage-paid, self-addressed envelope.**

POSTGRADUATE MEDICAL EDUCATION HISTORY

Name of Institution: University Hospitals of Cleveland

Complete Address: 11100 Euclid Ave
Street Address

Street Address

Cleveland — City; OH — State; 44106 — Zip Code(Postal Code)

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

Name and complete address of affiliated university/college:

Institution

Street Address

Street Address

City State Zip Code(Postal Code)

Enrollment and Participation: Our records indicate that Reider Mitchell W, MD
(type/print individual's name: Last, First, Middle, Suffix)

participated in the following:

Program Type (Internship,Residency, Fellowship)	PGY (1,2,3,4)	Department (Pathology, Internal Medicine, etc.)	Dates Attended (month/day/year) From	To	Completed (Yes/No)	Accredited By (ACGME, RSC, AOA or Not Accredited)
Residency	1	OB-GYN	7/1/97	6/30/98	Yes	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response.

Questions	Response	
Did this individual ever take a leave of absence or break from their medical education?	Yes	(No)
Was this individual ever placed on probation?	Yes	(No)
Was this individual ever disciplined or under investigation?	Yes	(No)
Were any negative reports regarding this individual ever filed by instructors?	Yes	(No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes	(No)

"Yes" responses to any of the questions above concerning unusual circumstances require a written explanation.

Certification: By my signature below, I, LASZLO SOGOR, M.D., Ph.D (type/print name), certify that the information contained in this report is an accurate account of the above named individual's official records maintained by this institution and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized.)

Signature: L.D.

Title: DIRECTOR, Residency PROGRAM

Date of Signature:

Telephone: (216) 844-1692

SEAL VERIFIED

Section V:

Examination History/ Score Transcripts

USMLE
United States
Medical
Licensing
Examination™

United States Medical Licensing Examination™
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 07/16/1998

State Medical Board of Ohio
ATTN: Ray Q Bumgarner, JD, Exec Director
77 S High St, 17th Floor
COLUMBUS, OH 43266-0315

Examinee: Reider, Mitchell William
USMLE ID#: 4-053-648-4
DOB: 01 / 21 / 1970
Alt Name(s):

STEP1 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
6 /1995	PASS	200	176	82	75	

STEP2 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
8 /1996	PASS	211	170	84	75	

STEP3 **The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.**

State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
OHIO	5 /1998	PASS	193	177	79	75	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

See reverse side for explanation of information reported above.

6325

Authenticity of USMLE™ Transcripts

Original, certified transcripts of United States Medical Licensing Examination (USMLE) scores are printed on blue safety paper and are produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The embossed USMLE seal in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history, and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For recent administrations, the mean and standard deviation of scores on the three-digit scale for first-time examinees from medical schools in the United States are approximately 205 and 20, respectively, and most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 82 on the two-digit scale is equivalent to a score of 200 on the three-digit scale. A score of 75 on the two-digit scale is always the minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each Step of USMLE is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 6 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

NOTATION REGARDING FSMB BOARD ACTION DATA BANK

The *Board Action Data Bank* of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. armed forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the *Bank*, 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 *Board Action Data Bank* are not disciplinary or otherwise prejudicial in nature. Such actions are reported to assure 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.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Special circumstances in connection with the administration of an examination may result in one of the following annotations being listed next to the score for that examination:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

Incomplete - The examinee sat for some but not all of the scheduled test books. **No score is reported.**

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* To obtain information regarding the nature of the irregular behavior, the full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

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.

Testing Accommodations - Following review and approval of a request from the examinee, testing accommodations were provided in the administration of the examination.

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43266-0315 • (614) 466-3934 • Website: www.state.oh.us/med/

DATE: 3/17/98

Univ Hosp-Cleveland

Dear Doctor:

Dr. Mitchell W. Reider, MD who is/was Resident OB/GYN 7/97 - PRESENT is applying to sit for Step 3 of the USMLE in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for the examination. ***To ensure processing of the physicians application please complete this form and return to the Ohio State Medical Board within two (2) weeks by either mail or FAX.*** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Information provided is considered confidential under Section 149.42 (A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known him/her? 2 yrs.

(2) What is/was your supervisory capacity? residency program director

(3) At what hospital? UNIV HOSP. of CLEVE

(4) How would you ~~rate~~ his/her medical knowledge and techniques? excellent

(5) In your opinion is he/she a person of good moral and ethical character? yes

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

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

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

(9) Would you recommend him/her to take the examination? yes.

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

Sincerely,

Penny E. Grubb

Penny E. Grubb
Chief, Licensure

Signature of Physician

Laszlo Sogor, MD, PhD
Name of Physician (please type or print clearly)

Program Director
Position

216/844-1692
Telephone number (include area code)

Direct Dial: (614) 466-9234
FAX: (614) 466-4670
Website: www.state.oh.us/med/
E-Mail Address: med_grubbp@ohio.gov

98 MAR 20 PM 4:32

4-22-99

MEDICINE OR OSTEOPATHIC MEDICINE - PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

NAME:	LAST (Surname): REIDER	FIRST: MITCHELL	MIDDLE: WILLIAM	SUFFIX (Jr., II): MD

HIGH SCHOOL OR EQUIVALENT:

SCHOOL NAME: CLEVELAND HEIGHTS HIGH SCHOOL			
CITY: CLEVELAND HEIGHTS	STATE: OHIO	COUNTRY: USA	
DATES ATTENDED: FROM: MO/YR 9/85	TO: MO/YR 6/88		

UNDERGRADUATE COLLEGE OR EQUIVALENT:

SCHOOL NAME: MIAMI UNIVERSITY			
CITY: OXFORD	STATE: OHIO	COUNTRY: USA	
DATES ATTENDED: FROM: MO/YR 8/88	TO: MO/YR 5/92	DEGREE RECEIVED: B.A.	

OK Rob/KW

SCHOOL NAME:			
CITY:	STATE:	COUNTRY:	
DATES ATTENDED: FROM: MO/YR /	TO: MO/YR /	DEGREE RECEIVED:	

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:

SCHOOL NAME: CASE WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE			
CITY: CLEVELAND	STATE: OHIO	COUNTRY: USA	
DATES ATTENDED: FROM: MO/YR 9/93	TO: MO/YR 5/97	DEGREE RECEIVED: M.D.	

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 93773 DATE ISSUED: MAR 26 1998

This is to certify that this applicant has met the preliminary education requirements for study in conformity with the Statutes of Ohio and the regulations of the State Medical Board of Ohio.

Ray L Bumgarner
Entrance Examiner

Anand G. Gargon
Secretary

Revised 05/20/97

CONTINUED ⇨

STATE MEDICAL BOARD OF OHIO
77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934
www.state.oh.us/med/

98 FEB 18 PM 5:43

Full Name: REIDER MITCHELL W.
Last First Middle Initial Suffix (Jr., II)

MAY 12-13, 1998 USMLE STEP 3 APPLICATION PACKET CHECKLIST

The following are included in the application packet. Check the following sections as completed and return this checklist with your application packet (postmarked) no later than **FEBRUARY 13, 1998**. Return *directly* to the Ohio State Medical Board at the above address.

- ☑ Enclosed is the completed Application for Examination (blue application) which includes:
  - ☑ Resume of Activities
  - ☑ Additional Information Questions
  - ☑ Affidavit and Release of Applicant
- ☑ Enclosed is the completed 1998 USMLE Application for Step 3 and Identification forms (white application).
- ☑ Enclosed is the Preliminary Education fee of $35.00. I have made the check/money order payable to the OHIO STATE MEDICAL BOARD.
- ☑ Enclosed is the examination fee of $420.00. I have made the check/money order payable to the FEDERATION OF STATE MEDICAL BOARDS.

Please be advised that the following must be completed by the appropriate individuals and submitted to the Ohio State Medical Board at the above address no later than **MARCH 20, 1998**.

- ☑ I have forwarded the Form 1's - Certificate of Recommendation (blue forms) to the two physicians who will complete the forms on my behalf .
- ☑ I have forwarded the AMA Physician Profile (white form), if applicable, to the American Medical Association.

Please be advised that the following application **must** be completed and forwarded to the Federation Credentials Verification Service (FCVS) at the address listed in that application no later than **FEBRUARY 13, 1998**.

- ☑ I have completed the Federation Credentials Verification Service (FCVS) application packet (gray application) and requested FCVS to forward my core credentials packet to the Ohio State Medical Board.

If you are required to take the Test of Spoken English (TSE) of the Educational Testing Service it is not required prior to taking the exam, however, it is required prior to licensure.

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION *AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.*

X Mitchell W. Reider 12/1/1999
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-07-6274-R	$305.00	01/01/00

MITCHELL WILLIAM REIDER,M.D.
1899 LAWNWAY ROAD
SOUTH EUCLID OH 44121

I wish to apply for Emeritus status: ☐

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ **SPECIALTY CODE(S) CORRECT AS LISTED**

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

⑆969696962⑆ 0935076274⑈ ⑈0000030500⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

Street

Street

City State Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☒ 1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?

YES ☐ NO ☒ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES ☐ NO ☒ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☒ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES ☐ NO ☒ 5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?

YES ☐ NO ☒ 6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances?

YES ☐ NO ☒ 7.) Had any clinical privileges or other authority to practice suspended,restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

Redacted
SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1999-2001 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Mitchell W. Reider 3/1/02
(SIGNATURE OF APPLICANT) MD (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-07-6274-R	$305.00	01/01/02	04/01/02

MITCHELL WILLIAM REIDER,M.D.
1899 LAWNWAY ROAD
SOUTH EUCLID OH 44121

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

☑ **SPECIALTY CODE(S) CORRECT AS LISTED**

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 | CODE2 | CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

3321 NORTH PARK BLVD
STREET
STREET
CLEVELAND HTS | OH | 44106
CITY | STATE | ZIP CODE
CUYAHOGA
COUNTY

0935076274 30500

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

1.) *Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?* YES ☐ NO ☒

2.) *Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.* YES ☐ NO ☒

3.) *Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?* YES ☐ NO ☒

4.) *Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?* YES ☐ NO ☒

5.) *Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.* YES ☐ NO ☒

6.) *Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?*** YES ☐ NO ☒

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
☐ *Check this Box if you have NO principal Practice address.*

1100 EUCLID AVE
Street
Street
CLEVELAND | OH | 44115
City | State | Zip Code
CUYAHOGA
County

03222002 711700
I 0039 020
076274
I SE 0000030500

REQUIRED:
SOCIAL SECURITY NUMBER

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2002 - 2004 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] MD 11/15/2003
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-07-6274-R	$305.00	01/01/04	04/01/04

MITCHELL WILLIAM REIDER,M.D.
2321 NORTH PARK BLVD
CLEVELAND HTS OH 44106

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

☐ **SPECIALTY CODE(S) CORRECT AS LISTED**

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.
2321 NORTH PARK BLVD
STREET
STREET
CLEVELAND HTS OH 44106
CITY STATE ZIP CODE
CUYAHOGA
COUNTY

0935076274 30500

APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

YES ☐ NO ☑ *1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?*

YES ☐ NO ☑ *2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.*

YES ☐ NO ☑ *3.) Have any malpractice awards or settlements been paid by you or on your behalf for acts occurring in any state other than Ohio?*

YES ☐ NO ☑ *4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?*

YES ☐ NO ☑ *5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.*

YES ☐ NO ☑ *6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?***

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
☐ *Check this Box if you have NO principal Practice address.*
16111 SOUTH GREEN ROAD
Street
SUITE 216
Street
SOUTH EUCLID OH 44121
City State Zip Code
CUYAHOGA
County

REQUIRED:
SOCIAL SECURITY NUMBER
Redacted

01142004 711700
0035 018
076274
4 SP 000030500

Date Posted: 3/15/2006 11:54:46 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.076274
License Name	MITCHELL REIDER
Email Address	

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   ..... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   ..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension,

reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 2/1/2008 3:02:30 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.076274
License Name	MITCHELL REIDER
Email Address	reider21@visn.net

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   ..... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   ..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... YES
2. Have you surrendered, consented to limitation of, or to suspension,

reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

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2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

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Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 2/18/2008 1:30:13 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.076274
License Name	MITCHELL REIDER
Email Address	reider21@visn.net

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   ..... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... OBSTETRICS & GYNECOLOGY
3. Please select one specialty from the field below, if applicable.
   ..... OBSTETRICS & GYNECOLOGY

CME-Physicians

1. Have you met the above CME requirements for your license?
   ..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... YES
2. Have you surrendered, consented to limitation of, or to suspension,

reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . n/a

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 2/27/2010 9:28:24 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS	1611 S GREEN RD SUITE 216 SOUTH EUCLID, OH 44121 Cuyahoga County United States of America (216) 381-2223 mitchell.reider@uhhospitals.org
CREDENTIAL MAIL ADDRESS	2321 NORTH PARK BLVD CLEVELAND HTS, OH 44106 Cuyahoga County United States of America (216) 421-2535 reider21@visn.net
MAIN	2321 NORTH PARK BLVD CLEVELAND HTS, OH 44106 Cuyahoga County United States of America (216) 421-2535 reider21@visn.net

License Information

License Number	35.076274
License Name	MITCHELL REIDER

Fees

Relicensure Fee	$305.00

Total Fees **$305.00**

Specialty Codes

1. Please select one specialty from the field below
. . . . . OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
. . . . . UNSPECIFIED
3. Please select one specialty from the field below, if applicable.
. . . . . UNSPECIFIED

CME-Physicians

1. Have you met the above CME requirements for your license?
. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
. . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
. . . . . NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
. . . . . NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?
. . . . . NO
5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . none

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 1/1/2012 4:36:02 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.076274
License Name	MITCHELL REIDER

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or

received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. . . . . 65+

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 1-4

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 1-4

4. "Education" - preceptor, mentor, etc.

. 5-9

5. "Volunteering" - providing medical and medical-related services at no cost

. 5-9

6. "Other" - medical professional activities not included in above categories

. 10-14

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 60-64

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 20-24

3. Enter the number of hours per week spent in "Emergency Room".

. 1-4

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 15-19

Workforce Counties

1. Enter the first zip code:

. 44121

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. 44106

4. Enter the second county:

. . . . . Cuyahoga

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Sign Language

2. Select a language from the drop down list.

. . . . . Spanish

3. Select a language from the drop down list.

. . . . . Polish

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.