New License Application

Submission Date: 02/20/2018

License Type - Telemedicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Title
First Name
Jessica
Middle Name
Louise
Last Name
Rubino
Maiden Name
Social Security Number
Redacted
Date of Birth
6/29/1985
Email Address
jlrubinomd@gmail.com
Phone Number
(217) 331-8043
Other Phone Number

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
What is your gender?
Female
What is your ethnicity?
White
In which country were you born?
United States
In which state were you born (if United States)?
Michigan
In which city were you born?
Detroit

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

709 E 32nd St
Austin
TX
78705-3107
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

81 Langton St Unit 11
San Francisco
CA
94103-3959
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
Has your spouse served in the military?
No
Country of Service

Service Branch

Are you still serving in the military (Active or Reserve)?

Were you honorably discharged from your service?

Service Start Date

Service End Date

Education History

List all undergraduate, graduate, and Medical Schools you have attended, including those from which you did not graduate. As you type, the name of your school should auto-populate. Once it does, click on it to select. If your school does not auto-populate, type and select Other. You will then enter your school's name and address in the fields that appear.

Educational Institution - Illinois College
Degree Type - Bachelor's
Degree - Biology/Chemistry
Enrollment date - 9/1/2003
Graduation date - 5/1/2007

Educational Institution - Southern Illinois University School Of Medicine
Degree Type - Other
Degree - Doctor of Medicine
Enrollment date - 8/1/2007
Graduation date - 7/27/2012

Employment History

List your employment history for the past five years including medical, non-medical, and post-graduate training. For any non-working time, you must indicate exactly what your activities were, such as vacation or seeking employment as well as your permanent address. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. Be sure to indicate the percentage of working time spent in clinical or other duties.

Employer / Non-Working Activity - Nurx
Job Title - Telemedicine Physician
Start Date - 8/23/2017
Street Address - 81 Langton St Unit 11
Employment City - San Francisco
Employment County - County
Employment State - California
Employment Zipcode - 94103
Employment Country - United States

Employer / Non-Working Activity - Whole Woman's Health, LLC
Job Title - Family Medicine Physician
Start Date - 5/1/2017
Street Address - 4025 East Southcross
Employment City - San Antonio
Employment County - County

Employment State - Texas
Employment Zipcode - 78222
Employment Country - United States

Employer / Non-Working Activity - Whole Woman's Health Alliance
Job Title - Family Medicine Physician
Start Date - 5/1/2017
Street Address - 8401 N Interstate 35 Frontage Road
Employment City - Austin
Employment County - County
Employment State - Texas
Employment Zipcode - 78753
Employment Country - United States

Employer / Non-Working Activity - Beacon Family Health Care
Job Title - Family Medicine Physician
Start Date - 11/1/2016
Street Address - 4208 Medical Parkway TX
Employment City - Austin
Employment County - County
Employment State - Texas
Employment Zipcode - 78756
Employment Country - United States

License Verification

You must complete the License Verification component if you hold or have ever held a professional license or certification in a state or Canadian Province. You must request verification of all your applicable licenses and certifications from the issuing state or Canadian province to be sent to the State Medical Board of Ohio. Please include both active and inactive professional licenses or certifications.

125063694
Other
Illinois Department of Financial and Professional Regulation
EXPIRED
United States
Illinois

049174284
Other
Illinois Department of Financial and Professional Regulation
Not Renewed
United States
Illinois

4301111191

Doctor of Medicine (MD)
Department of Licensing and Regulatory Affairs
Active
United States
Michigan

R1121
Doctor of Medicine (MD)
Texas Medical Board
Active
United States
Texas

Examination Tracking

List each licensure examination you have taken (USMLE, NBME, COMLEX USA, NBOME, LMCC, PMLEXIS, etc.)

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Medical Speciality Certification - American Board of Medical Specialties (ABMS)
Medical Speciality - Family Medicine
Medical SubSpeciality - null

Residency Component

List all post-graduate training programs you have attended, including those you did not complete. As you type, the name of your Hospital/Institution should auto-populate. Once it does, click on it to select. If your Hospital/Institution does not auto-populate, type and select Other. You will then enter your Hospital/Institution name in the fields that appear.

Residency Number - RES06848
Hospital Name - St Joseph's Hospital and Med Ctr
Address - 2900 North Lake Shore Drive
City - Chicago
State - IL

ZipCode - 60657
Country - United States
PG Years - 1
PG Type - Internship
Department/Specialty - Family Medicine
Start Date - 7/1/2013
End Date - 7/1/2014
Successfully Completed? - true

Residency Number - RES06849
Hospital Name - University of Texas Southwestern Medical Center
Address - 5323 Harry Hines Blvd Stop 7200
City - Dallas
State - TX
ZipCode - 75390
Country - United States
PG Years - 2
PG Type - Residency
Department/Specialty - Family Medicine
Start Date - 7/1/2014
End Date - 8/24/2016
Successfully Completed? - true

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue.

Question - Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?
Answer - No

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - 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 or podiatry school, clinical clerkship, externship, preceptorship, residency, postdoctoral training program, or graduate medical education program?
Answer - Yes

Question - Have you ever transferred from one graduate medical education program or postdoctoral training program to another?
Answer - No

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - Have you ever been requested to appear before any board; bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?
Answer - No

Question - 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?
Answer - No

Question - Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
Answer - No

Question - 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?
Answer - No

Question - Have you ever been denied or have you ever 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?
Answer - No

Question - Have you ever pied guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders.
Answer - No

Question - Have you ever been arrested, 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)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders.
Answer - No

Question - 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? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10years 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.
Answer - No

Question - Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?
Answer - No

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

Answer - No

Question - In the past five years, have you been diagnosed as having, or been hospitalized for a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? You may answer "NO" to this question if you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Section 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.
Answer - No

Question - Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?
Answer - No

Question - Are you currently engaged in the illegal use of controlled substances?
Answer - No

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Title - FCVS
Description -

Attached file - Rubino, Jessica Louise.pdf

Title - License Verification
Description - I attest that I will request License Verification(s) from any state(s), jurisdiction(s) or Canadian province(s) where I currently hold or previously held a full license. VERIDOC, electronic or standardized

letters are acceptable for license verification.
Attested - Attestation complete

Title - License Verification
Description - I attest that I will request License Verification(s) from any state(s), jurisdiction(s) or Canadian province(s) where I currently hold or previously held a full license. VERIDOC, electronic or standardized letters are acceptable for license verification.
Attested - Attestation complete

Title - AMA (MD) Physician Profile
Description - I attest to have a physician profile from the American Medical Association (AMA) (https://profiles.ama-assn.org/amaprofiles/) sent to the Board.
Attested - Attestation complete

Title - License Verification
Description - I attest that I will request License Verification(s) from any state(s), jurisdiction(s) or Canadian province(s) where I currently hold or previously held a full license. VERIDOC, electronic or standardized letters are acceptable for license verification.
Attested - Attestation complete

Title - Supporting Documents
Description - 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…

Attached file - OH App Explanation.docx

Title - FBI Report
Description - I acknowledge as an applicant I am required to complete an FBI criminal records check and the results should be sent directly to the State Medical Board of Ohio.
Attested - Attestation complete

Title - BCI Report
Description - I acknowledge as an applicant I am required to complete an Ohio BCI criminal records check and the results should be sent directly to the State Medical Board of Ohio.
Attested - Attestation complete

Title - License Verification
Description - I attest that I will request License Verification(s) from any state(s), jurisdiction(s) or Canadian province(s) where I currently hold or previously held a full license. VERIDOC, electronic or standardized letters are acceptable for license verification.
Attested - Attestation complete

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

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

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

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

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

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to the credential for which I have applied being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of the credential for which I have applied.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 02/20/2018 12:32:41
Type your First Name and Last Name as they appear on the application to sign electronically.
Jessica Rubino

Submit your Application -After clicking the ‘Submit’ button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.

Ohio | State Medical Board of Ohio

med.ohio.gov 30 E. Broad St., 3rd Floor · Columbus, OH 43215 -6127 · (614) 466 -3934 · Fax (614) 644 -1464

Last Name: Rubino | First Name: Jessica | MI: L

Chronology of Activities: *List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using* ***MONTH*** *and* ***YEAR****. For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address. If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.* ***DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM****. Be sure to indicate the percentage of working time spent in clinical /administrative duties.*

Dates: From/To | Activity

FROM: Month: 08 | Year: 2007

TO: Month: 07 | Year: 2012 | ☐ In Progress

Activity/Employer Name *(Non-Working*)*: Southern Illinois University School Of Medicine

Activity Address:

City: Springfield | State: IL | Zip Code: 62702

Position / Department: Student

Percent Clinical: 100 | Percent Administrative: 0

☐ Employment ☐ Staff Privileges ☐ Administrative ☑ Other, Please describe below

Medical School

Dates: From/To | Activity

FROM: Month: 08 | Year: 2012

TO: Month: 09 | Year: 2012 | ☐ In Progress

Activity/Employer Name *(Non-Working*)*: Non working time

Activity Address:

City: | State: | Zip Code:

Position / Department:

Percent Clinical: | Percent Administrative:

☐ Employment ☐ Staff Privileges ☐ Administrative ☑ Other, Please describe below

Seeking employment

Dates: From/To | Activity

FROM: Month: 10 | Year: 2012

TO: Month: 06 | Year: 2013 | ☐ In Progress

Activity/Employer Name *(Non-Working*)*: Catapult Health

Activity Address: 8144 Walnut Hill Lane Suite 1100

City: Dallas | State: TX | Zip Code: 75231

Position / Department: Medical Assistant

Percent Clinical: 100 | Percent Administrative: 0

☑ Employment ☐ Staff Privileges ☐ Administrative ☐ Other, Please describe below

Dates: From/To | Activity

FROM: Month 07 Year 2013
TO: Month 07 Year 2014 ○ In Progress

Activity/Employer Name *(Non-Working*)*: St. Joseph's Hospital
Activity Address:
City: Chicago State: IL Zip Code: 60657
Position / Department: Family Medicine
Percent Clinical: 100 Percent Administrative: 0
○ Employment ○ Staff Privileges ○ Administrative ☑ Other, Please describe below
Internship

Dates: From/To | Activity

FROM: Month 08 Year 2014
TO: Month 08 Year 2016 ○ In Progress

Activity /Employer Name *(Non-Working*)*: University of Texas Southwestern Medical Center
Activity Address:
City: Dallas State: TX Zip Code: 75390
Position / Department: Family Medicine
Percent Clinical: 100 Percent Administrative: 0
○ Employment ○ Staff Privileges ○ Administrative ☑ Other, Please describe below
Residency

Dates: From/To | Activity

FROM: Month 09 Year 2016
TO: Month 10 Year 2016 ○ In Progress

Activity/Employer Name *(Non-Working*)*: Non working time
Activity Address:
City: State: Zip Code:
Position / Department:
Percent Clinical: Percent Administrative:
○ Employment ○ Staff Privileges ○ Administrative ☑ Other, Please describe below
Seeking employment

Dates: From/To | Activity

FROM: Month 11 Year 2016
TO: Month Present Year ○ In Progress

Activity/Employer Name *(Non-Working*)*: Beacon Family Health Care
Activity Address: 4208 Medical Parkway
City: Austin State: TX Zip Code: 78756
Position / Department: Family Medicine Physician
Percent Clinical: 100 Percent Administrative: 0
☑ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Dates: From/To | Activity

FROM: Month 07 Year 2013
TO: Month 07 Year 2014
○ In Progress

Activity/Employer Name *(Non-Working*)*: St. Joseph's Hospital
Activity Address:
City: Chicago State: IL Zip Code: 60657
Position / Department: Family Medicine
Percent Clinical: 100 Percent Administrative: 0
○ Employment ○ Staff Privileges ○ Administrative ☑ Other, Please describe below
Internship

Dates: From/To | Activity

FROM: Month 08 Year 2014
TO: Month 08 Year 2016
○ In Progress

Activity /Employer Name *(Non-Working*)*: University of Texas Southwestern Medical Center
Activity Address:
City: Dallas State: TX Zip Code: 75390
Position / Department: Family Medicine
Percent Clinical: 100 Percent Administrative: 0
○ Employment ○ Staff Privileges ○ Administrative ☑ Other, Please describe below
Residency

Dates: From/To | Activity

FROM: Month 09 Year 2016
TO: Month 10 Year 2016
○ In Progress

Activity/Employer Name *(Non-Working*)*: Non working time
Activity Address:
City: State: Zip Code:
Position / Department:
Percent Clinical: Percent Administrative:
○ Employment ○ Staff Privileges ○ Administrative ☑ Other, Please describe below
Seeking employment

Dates: From/To | Activity

FROM: Month 11 Year 2016
TO: Month Present Year
○ In Progress

Activity/Employer Name *(Non-Working*)*: Beacon Family Health Care
Activity Address: 4208 Medical Parkway
City: Austin State: TX Zip Code: 78756
Position / Department: Family Medicine Physician
Percent Clinical: 100 Percent Administrative: 0
☑ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Ohio | State Medical Board of Ohio

med.ohio.gov 30 E. Broad St., 3rd Floor · Columbus, OH 43215 -6127 · (614) 466 -3934 · Fax (614) 644 -1464

Last Name: Rubino | First Name: Jessica | MI: L

Chronology of Activities: *List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using* ***MONTH*** *and* ***YEAR****. For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address. If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.* ***DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM****. Be sure to indicate the percentage of working time spent in clinical /administrative duties.*

Dates: From/To | Activity

FROM: Month: 05 | Year: 2017
TO: Month: 03 | Year: 2018 | ○ In Progress

Activity/Employer Name *(Non-Working*)*: Whole Woman's Health, LLC
Activity Address: 4025 East Southcross
City: San Antonio | State: TX | Zip Code: 78222
Position / Department: Family Medicine Physician
Percent Clinical: 100 | Percent Administrative: 0
☑ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Dates: From/To | Activity

FROM: Month: 05 | Year: 2017
TO: Month: 03 | Year: 2018 | ○ In Progress

Activity/Employer Name *(Non-Working*)*: Whole Woman's Health Alliance
Activity Address: 8401 N Interstate 35 Frontage Road
City: Austin | State: TX | Zip Code: 78753
Position / Department: Family Medicine Physician
Percent Clinical: 100 | Percent Administrative: 0
☑ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Dates: From/To | Activity

FROM: Month: 08 | Year: 2017
TO: Month: Present | Year: | ○ In Progress

Activity/Employer Name *(Non-Working*)*: Nurx
Activity Address: 81 Langton St Ste 11
City: San Francisco | State: CA | Zip Code: 94103
Position / Department: Telemedicine Physician
Percent Clinical: 100 | Percent Administrative: 0
☑ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

To Whom It May Concern,

As a 3rd year resident at University of Texas Southwestern in 2016, I was placed on probation for several weeks after a page sent to my pager failed to go through and I failed to respond. No patient harm was done due to this error. I was taken off probation after completing the requirements, which included answering all pages and completing all outstanding patient charts. No further action was taken.

Jessica L Rubino, MD

R-128284

Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

STATE MEDICAL BOARD OF OHIO
30 E BROAD STREET 3RD FLOOR
COLUMBUS, OH 43215-6127

May 3, 2018

For: STATE MEDICAL BOARD OF OHIO

In response to a recent request, we verify the following information:

****

Physician:	JESSICA LOUISE RUBINO, MD
License:	R1121
Date Issued:	12/16/2016
Licensed by:	
Date of Birth:	1985
Medical School:	SOUTHERN ILLINOIS UNIV SCH OF MED, SPRINGFIELD
Graduation Year:	2012
Permit Expires:	02/28/2019

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

Investigation Status:

Not applicable.

****

If you have any further questions, please contact the Hearings division

Sincerely,

Joanna Humflet

Customer Information Center

BOARD SEAL

MEDICAL BOARD

MAY 07 2018

Texas Medical Board

MAILING ADDRESS: P.O. BOX 2029 • AUSTIN TX 78768-2029
PHONE: (512) 305-7010

State Board Verification of Postgraduate Resident Permit

May 3, 2018

STATE MEDICAL BOARD OF OHIO
30 E BROAD STREET 3RD FLOOR
COLUMBUS, OH 43215

NAME: JESSICA LOUISE RUBINO MD

POSTGRADUATE RESIDENT PERMIT NUMBER: BP10051026

DATES OF PERMIT:

Begin Date: 07/01/2014
Expiration Date: 08/24/2016
Terminated Date: 08/24/2016

PROGRAM: UNIV OF TX SOUTHWESTERN MED CTR (3 YR PROGRAM)

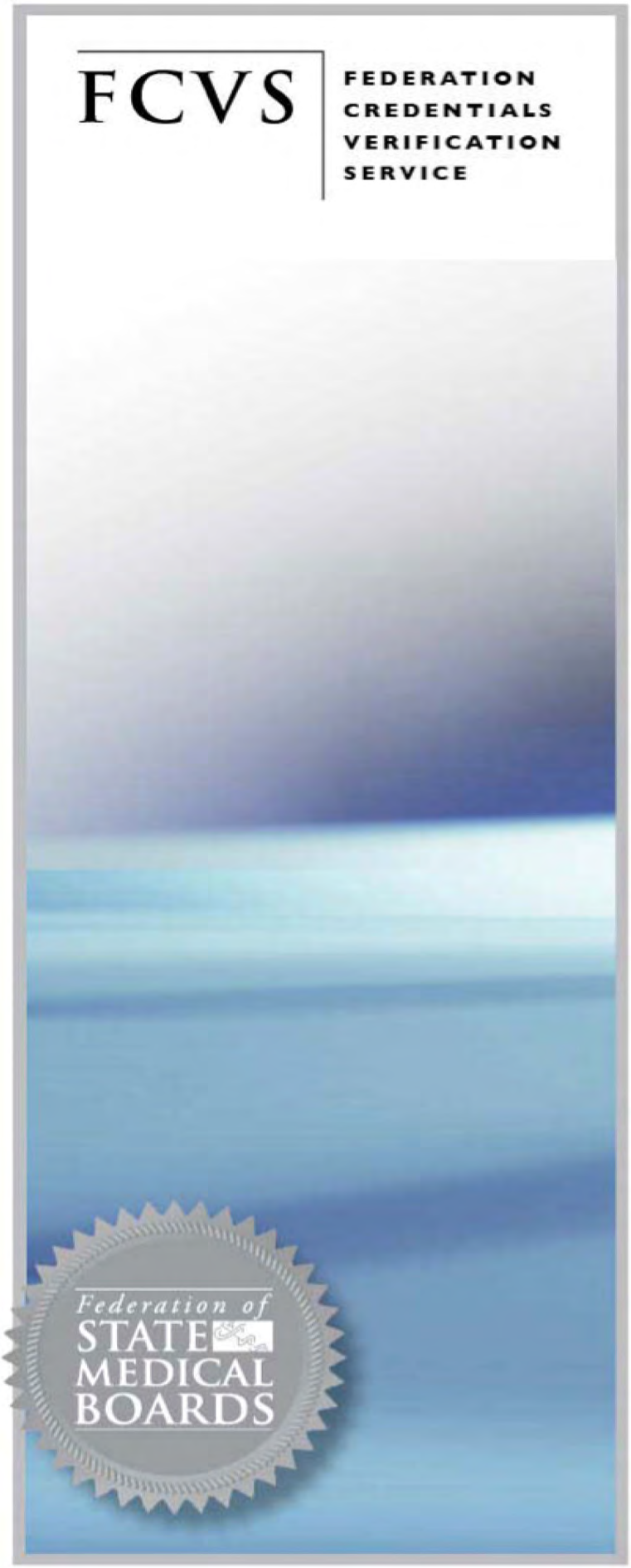
DISCIPLINARY ACTION: NONE

For further information please contact the Registrations Department at:
registrations@tmb.state.tx.us

Sincerely,

Joanna Humfleet

J. Humfleet
Registrations Department
Texas Medical Board



Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Rubino, Jessica Louise**
Social Security Number:	Redacted
Date of Birth:	**June 29, 1985**
FID#:	**217877273**
Recipient:	**OH - State Medical Board of Ohio**
Delivery Date:	**02/13/2018**

ABOUT THIS PROFILE

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

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

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

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

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

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

NOTARY PUBLIC CLINISHA BLAKE

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

Rubino
Applicant's **Printed** Last Name

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

12/13/17
Date of Signature (**must** correspond to date of notarization)

State of Texas, County of Travis,

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 13th day of Dec., 2017.

Notary Public Signature: Clinisha B

My Notary Commission Expires: 9/3/19

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

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

FCVS ID Number
FCVS

FID Number
217877273

217 877 273

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Federation of STATE MEDICAL BOARDS

Biographic Information

Medical professional Name(s): **Rubino, Jessica Louise**

Date of Birth: June 29, 1985

Place of Birth: Wayne, MI, UNITED STATES

Contact Information

Home Address: 709 E 32nd St
Austin, TX 78705
UNITED STATES

Mobile Phone: (217) 331-8043

Email: jlrubinomd@gmail.com

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Rubino Jessica Louise
Last First Middle

FCVS ID Number: FCVS

Notary – Please complete the section below:

State of Texas County of Travis

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

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 13th, of (Month) Dec., (Year) 2017.

Notary Public Signature: Clinisha Blake

Commission Expiration Date* (Month) 9 / (Day) 3 / (Year) 19

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided. If you are in California, the notary may attach a California All-Purpose Acknowledgement form to this document.**

Notary Stamp Here

CLINISHA BLAKE
MY COMMISSION EXPIRES
SEPTEMBER 3, 2019

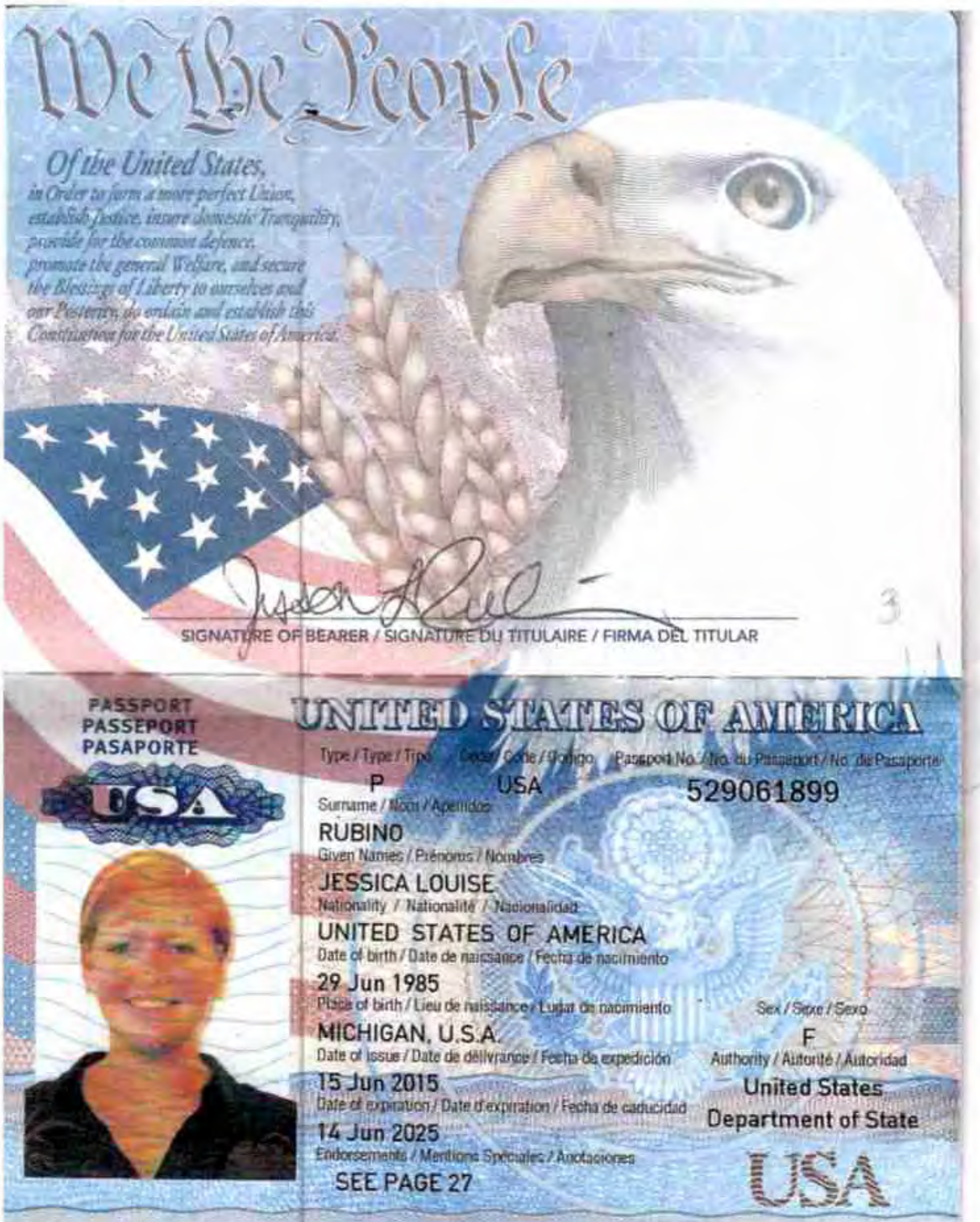
Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

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

FCVS ID Number
FCVS

FID Number
217877273

217 877 273


We the People
Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquility,
provide for the common defence,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do ordain and establish this
Constitution for the United States of America.
SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
PASSPORT
PASSEPORT
PASAPORTE
USA
UNITED STATES OF AMERICA
Type / Type / Tipo
P
Code / Code / Código
USA
Passport No. / No. du Passeport / No. de Pasaporte
529061899
Surname / Nom / Apellidos
RUBINO
Given Names / Prénoms / Nombres
JESSICA LOUISE
Nationality / Nationalité / Nacionalidad
UNITED STATES OF AMERICA
Date of birth / Date de naissance / Fecha de nacimiento
29 Jun 1985
Place of birth / Lieu de naissance / Lugar de nacimiento
MICHIGAN, U.S.A.
Sex / Sexe / Sexo
F
Date of issue / Date de délivrance / Fecha de expedición
15 Jun 2015
Authority / Autorité / Autoridad
United States
Department of State
Date of expiration / Date d'expiration / Fecha de caducidad
14 Jun 2025
Endorsements / Mentions Spéciales / Anotaciones
SEE PAGE 27
USA
P<USARUBINO<<JESSICA<LOUISE<<<<<<<<<<<<<<<<<<<
5290618991USA8506298F2506148268555864<713480

217 877 273

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

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

Start Date	End Date	Activity Type	Location
08/01/2007	07/27/2012	Medical Education	Southern Illinois University School Of Medicine Springfield Illinois UNITED STATES
08/01/2012	06/01/2013	Work	Catapult Health 8144 Walnut Hill Lane Suite 1100 Dallas, Texas UNITED STATES
07/01/2013	07/01/2014	Postgraduate Training	Presence Saint Joseph Hospital (Chicago) Program Chicago Illinois UNITED STATES
07/01/2014	08/24/2016	Postgraduate Training	University of Texas Southwestern Medical School Program Dallas Texas UNITED STATES

End of Chronology of Activities report for: Rubino, Jessica Louise

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

Federation of STATE MEDICAL BOARDS

Medical Education

Medical School: **Southern Illinois University School Of Medicine**

Location: Springfield, IL

UNITED STATES

Credentials Analysis Information for Medical Education

Issue:
FCVS has identified a medical education Discrepancy at Southern Illinois University School Of Medicine.

Unusual Circumstances

Solution(s):
FCVS does not follow up with the Medical Professional or the institution with inconsistent information on Unusual Circumstances questions.

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

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

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

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

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

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

Institution Name: Southern Illinois University School Of Medicine

Address Line 1:

Address Line 2:

City: **State/Province:** **Zip Code (Postal Code):**

Country:

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

Premedical Education:

Years of education required for admission to your medical school: 90 Sem hrs - min: Bachelors degree preferred

Credential/degree presented by the applicant for admission to your medical school: BS Biology/Chemistry & Spanish - Illinois College

Enrollment and Participation: Our records indicate that Rubino Jessica Louise

(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 201 weeks of medical education on the following dates: **From:** 8/13/07 (Month Day Year) **To:** 7/27/12 (Month Day Year)

This individual

Was awarded the degree of Doctor of Medicine on 7/27/12 (Month Day Year)

Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

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

OFFICIAL SEAL · BOARD OF TRUSTEES · SOUTHERN ILLINOIS UNIVERSITY · CHARTERED 1869 · STATE OF ILLINOIS

217877273

Watermark

For FCVS internal use only.

SEAL VERIFIED

Name: Karla Heneby

Signature: Karla Heneby

Title: Registrar

Date of Signature: 2/6/18 **Phone:** 217 545-2860

Fax: 217 545-5538 **Email:** kheneby@siumed.edu

217 877 273 1421 217877273

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

* See Transcript

Unusual Circumstances

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

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

Personal/Family	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
* Academic remediation ✓	From (Mo/Yr) 7/08	To (Mo/Yr) 5/10	X Approved	___ Unapproved
Health	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Financial	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Participation in joint degree Program (e.g., MD/PhD)	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Participation in non-degree research	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved
Other	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___	___ Approved	___ Unapproved

Please Specify:
Repeat / Remediation of Sophomore / Yr 2 Curriculum
Pediatrics Clerkship Remediation - Had to repeat the written exam.

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

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

* Academic Probation ✓	From (Mo/Yr) 07/08	To (Mo/Yr) 5/10
Probation for unprofessional conduct/behavioral	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___
Probation for other reason	From (Mo/Yr) ___/___	To (Mo/Yr) ___/___

Please specify a reason:
Was placed on academic probation due to being required to repeat Yr 2

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

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

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

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

X YES ___ NO

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements:
* Remediation of Sophomore / Yr 2 Curriculum
* Pediatrics Clerkship Remediation - Had to repeat the written exam. * Was required to repeat Yr 2 on academic probation.

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Rubino, Jessica Louise

Southern Illinois University School Of Medicine

Unusual Circumstances

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

End of Applicant Reported Unusual Circumstances report for: Rubino, Jessica Louise

SOUTHERN ILLINOIS UNIVERSITY
SCHOOL OF MEDICINE

Office of Student Affairs
P.O. Box 19624, Springfield, IL 62794-9624

Name: Rubino, Jessica Louise Date of Birth: 06/29/1985

Date of Matriculation: 08/13/2007

Degree: DOCTOR OF MEDICINE Date Conferred: 07/27/2012

Course Title	Dates	# of Weeks	Credits	Evaluation
FRESHMAN YEAR, CARBONDALE	08/13/2007 - 06/05/2008			S
Cardiovascular/Renal/Respirato		14.00		
Sensorimotor Systems & Behav		12.00		
Endocrine/Reproduction/Gastro		12.00		
Clinical & Research Experience		3.00		
SOPHOMORE YEAR, SPRINGFIELD	07/07/2008 - 06/29/2009			U
Orientation		1.00		
Doctoring		1.00		
Hematology/Immuno/Infection		7.00		
Cardiovascular/Resp/Renal		10.00		
Neuromuscular/Behavior		10.00		
Endocrine/Reproduction/GI		10.00		
SOPHOMORE YEAR, SPRINGFIELD	08/10/2009 - 05/23/2010			S*
Orientation		1.00		
Doctoring		1.00		
Hematology/Immunoy/Infection		7.00		
Cardiovascular/Resp/Renal		10.00		
Neuromuscular Behavior		10.00		
Endocrine/Reproduction/GI		10.00		
Junior/Senior Years, Springfield				
Clerkships				
Psychiatry Clerkship	09/27/2010 - 11/01/2010	6.00		S
Obstetrics/Gynecology Clkshp	11/08/2010 - 12/13/2010	6.00		S
Doctoring Year 3: Phys/Pt Rel.	01/03/2011 - 01/10/2011	2.00		S
Internal Medicine Clerkship	01/17/2011 - 03/21/2011	10.00		S
Surgery Clerkship	04/25/2011 - 06/27/2011	10.00		S
Fam/Comm Medicine Clerkship	07/05/2011 - 08/08/2011	6.00		S
Pediatrics Clerkship	11/07/2011 - 12/12/2011	6.00		S*
Neurology Clerkship	01/30/2012 - 02/20/2012	4.00		S
Doctoring Year 4: Society, Law	02/27/2012 - 03/05/2012	2.00		S
Electives			Credits	
Issues in Minority Health Care	09/06/2010 - 09/06/2010	1.00		S
Community Hlth Serv & Resource	09/13/2010 - 09/13/2010	1.00		S
Intro to Cutaneous Medicine	04/11/2011 - 04/18/2011	2.00		S
Basic Science Review, Step 1 Falcon Physician Review	08/15/2011 - 09/26/2011	7.00		S
Patient Education	01/23/2012 - 01/23/2012	1.00		S
Spanish for the Medical Prof	03/12/2012 - 05/14/2012	1.00		S
Nutrition in Pediatric Care	03/12/2012 - 03/12/2012	1.00		S
PT/OT/Speech&Language Therapy	03/19/2012 - 03/19/2012	1.00		S
Emergency Medicine-Springfield	04/09/2012 - 04/30/2012	4.00		S
Physical Activity Basics&Teach	05/07/2012 - 05/07/2012	1.00		S
Patient Education	05/14/2012 - 05/14/2012	1.00		S
Emerging Trends in Public Hlth	05/21/2012 - 05/21/2012	1.00		S
Midwifery Elective	05/28/2012 - 05/28/2012	1.00		S
Public Health Leadership	06/04/2012 - 06/04/2012	1.00		S

SEAL VERIFIED

RAISED SEAL NOT REQUIRED
Printed on Scrip Safe® security paper

Registrar: Karla Hensley

Date Issued: 2/6/18 217 877 273

Grading Key 1988-1992
H = Honors
S = Satisfactory
U = Unsatisfactory
I = Incomplete

Grading Key 1993 -
H = Honors
S = Satisfactory
S* = Satisfactory After Remediation
U = Unsatisfactory
I = Incomplete

SOUTHERN ILLINOIS UNIVERSITY
SCHOOL OF MEDICINE
Office of Student Affairs
P.O. Box 19624, Springfield, IL 62794-9624

Name: Rubino, Jessica Louise

Course Title	Dates	# of Weeks	Evaluation
Junior/Senior Years, Springfield			
Electives		**Credits**	
History of Family Practice	06/18/2012 - 06/25/2012	2.00	S
Alternative Systems of Healing	07/02/2012 - 07/02/2012	1.00	S
Minority Healthcare	07/09/2012 - 07/16/2012	2.00	S
Alternative Systems of Healing	07/23/2012 - 07/23/2012	1.00	S

*** End of Transcript ***

RAISED SEAL NOT REQUIRED
Printed on Scrip Safe® security paper

Registrar: Karla Hensley

Date Issued: 2/6/18

217 877 273

SEAL VERIFIED

Grading Key
1988-1992
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U = Unsatisfactory
I = Incomplete

Grading Key
1993 -
H = Honors
S = Satisfactory
S* = Satisfactory After Remediation
U = Unsatisfactory
I = Incomplete

217 877 Karla Henebry, Expires 5/21/20

Certified copy of original medical school diploma

KARLA HENEBRY
Official Seal
Notary Public - State of Illinois
My Commission Expires May 21, 2020

KARLA H
Officia
Notary Public -
My Commission Ex
2020

Southern Illinois University

Carbondale

School of Medicine

On recommendation of the Chancellor and Faculty,
the Board of Trustees, by virtue of the authority vested in it, has
conferred on

Jessica Louise Rubino

the degree of

Doctor of Medicine

and has granted this Diploma as evidence thereof
the twenty-seventh day of July, 2012

SEAL
VERIFIED

Rita Cheng
Chancellor

J Kevin Dorsey
Dean

SOUTHERN ILLINOIS UNIVERSITY · DEO VOLENTE · CHARTERED 1869

Glenn Poshard
President

John Dunn
Chairman of Board

Postgraduate Training

Accreditation ID: **1201611103**

Institution: **Presence Saint Joseph Hospital (Chicago) Program**

Location: Chicago, IL
UNITED STATES

Accreditation ID: **1204821361**

Institution: **University of Texas Southwestern Medical School Program**

Location: Dallas, TX
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
FCVS has identified a postgraduate training Discrepancy at University of Texas Southwestern Medical School Program.

Unusual Circumstances

Solution(s):
FCVS does not follow up with the Medical Professional or the institution with inconsistent information on Unusual Circumstances questions.

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: Presence Saint Joseph Hospital (Chicago) Program
Specialty: Family Medicine
Address: Chicago, IL

Attention: **Program Director**
Affiliated University: _____

Verification For:

Name: Jessica Louise Rubino
DOB: 06/29/1985
Individual's Name on Record (If different from above): _____

Program Participation:

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

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

Report Internships, Residencies and Fellowships separately.

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

PGY: 1
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: FAMILY MEDICINE
From: 6/25/13 To: 6/24/14
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

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

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

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

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

Please explain any "Yes" response from above:

ELECTRONIC SEAL VERIFIED

Certification:

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

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

Name: LUIS T. GARCIA, MD Signature: Luis T. Garcia
Title: PROGRAM DIRECTOR Date of Signature: 2/1/18
Tel: 773-665-3300 Fax: _____ E-Mail: HBOSKOVIC@presencehealth.org

Rev. 01/21/2016 FID: 217877273 ACGME ID: 1201611103 GME CODE: _____

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name:	Rubino, Jessica Louise
Accreditation ID:	1201611103
Institution:	Presence Saint Joseph Hospital (Chicago) Program
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 7/1/2013 - 7/1/2014 **Internship**

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

End of Applicant Reported Unusual Circumstances report for: Rubino, Jessica Louise

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Graduate Medical Education

Federation of STATE MEDICAL BOARDS

Institution: University of Texas Southwestern Medical School Program **Affiliated University:** University of Texas Southwestern Medical School

Address Line 1:

Address Line 2:

Country: US **City:** Dallas **State/Prov.:** TX **Zip Code:**

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

Verification For: Rubino, Jessica Louise **Date of Birth:** June 29, 1985

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

Program Participation:

Important:

Report Incomplete Training Levels (year) separate from those that were successfully completed.

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

Report Internships, Residencies and Fellowships separately.

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

Program Type	Training Level	From	To	Successfully Completed?	Specialty/Subspecialty	Accredited by
R	2-2	07/01/2014	08/24/2015	Yes	Family Medicine	ACGME
	Rotation Information Not Available					
R	3-3	08/25/2015	08/24/2016	Yes	Family Medicine	ACGME

Program Type **Training Level:** **Specialty/Subspecialty:**
From: **To:**
Successfully Completed? **If no, was credit awarded?**
Accredited by:

Unusual Circumstances

Check the correct response.

Omitted responses require written explanation.

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

1. Did this individual ever take a leave of absence or extension from his/her training? Yes
   If "Yes" provide start and end dates: **From:** 12/24/2014 **To:** 02/18/2015
2. Was this individual ever placed on probation? ..... Yes
3. Was this individual ever disciplined or placed under investigation? ..... Yes
4. Were any negative reports for behavioral reason ever filed by instructors? ..... No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? No

Please explain any "Yes" response from above:

1.Please refer to attached document. 2.Please refer to attached document. 3.Please refer to attached document.

Attestation

Affix Institutional Seal Here.

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

Watermark

For FCVS internal use only.

ELECTRONIC SEAL VERIFIED

Completion attests the information above is an accurate account of this individual's records and is true and correct. Signature line must contain original signature or electronic typed signature of program director

Print Name: ZubairSyed **MD/DO:** Yes

Signature: *Zubair Syed*

Title: Program Director **Date:** 01/29/2018

Tel: (214) 648-8219 **Fax:** (214) 353-0604 **Email:** Zubair.Syed@UTSouthwestern.edu

217877273 115396 217877273

UT Southwestern
Medical Center

Department of Family and Community Medicine

David Schneider, MD, MSPH
Department Chair

Zubair Syed, MD
Assistant Professor
Program Director

Mahdi Awwad, MD
Assistant Professor

Nitin Budhwar, MD, FAAFP
Associate Professor

Rachel Chamberlain, MD
Assistant Professor

Philip Day, PhD
Faculty Associate

Nora Gimpel, MD
Associate Professor

Zaiba Jetpuri, DO
Assistant Professor

Mahdi Awwad, MD
Assistant Professor

Neelima Kale, PhD, MD, MBA
Assistant Professor

Tamara McGregor, MD
Associate Professor

Tasaduq Mir, MD
Assistant Professor

Patti Pagels, PA-C
Associate Professor

Turya Nair, MD
Assistant Professor

Dan Sepdham, MD, FAAFP
Associate Professor

Amer Shakil, MD, FAAFP
Professor

Joe Ventimiglia, MD, PhD
Assistant Professor

January 29, 2018

To Whom It May Concern

As pertaining to Q#s 1,2 and 3 in the "Unusual Circumstances" section:

Jessica Rubino, MD tested preliminarily as "non-negative" in her urine screen for cannabinoids on December 23, 2014, which result subsequently was confirmed on the final test results. Her employer, Parkland Health and Hospital System, referred her to its Committee on Physician Peer Review and Assistance (COPPRA), and reported to the training program that she would be urine drug tested weekly, and was not to report to the training program until she was cleared by the COPPRA to resume her training. Dr. Rubino was absent from the training program from 12/24/2014 to 02/18/2015

Dr. Rubino was placed on probation from 5/24/2016 until 7/22/2016 for issues related to Patient care and Professionalism. She successfully fulfilled all requirements of her probation.

During her training, Dr. Rubino was under administrative investigation by the Texas Medical Board(TMB). The Residency program does not have any official notification from the TMB regarding the final status of the investigation.

Dr. Rubino's privileges and other professional activities have never been limited, restricted or denied in any way during her training. and she has never exhibited any impairment affecting skills or judgment. Dr. Rubino has always displayed good moral and ethical character.

Syed Ubais Ahmed

Zubair Syed, MD
Program Director

5920 Forest Park Rd, Suite 651 /Dallas, Texas 75390-9165 / (214) 648-1399 fax (214) 353-0604

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name:	Rubino, Jessica Louise
Accreditation ID:	1204821361
Institution:	University of Texas Southwestern Medical School Program
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 7/1/2014 - 8/24/2016 **Residency**

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

End of Applicant Reported Unusual Circumstances report for: Rubino, Jessica Louise

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Date: 02/13/2018

Federation Credentials Verification Service

ATTN: FCVS

FCVSID: 349452

Examinee: Rubino, Jessica Louise **Examinee ID:** 52218237

Alt Name(s): **Date of Birth:** 06/29/1985

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

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
1/23/2012	Pass	195	(188)	
10/27/2011	Fail	186	(188)	
8/23/2010	Fail	182	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
6/30/2012	Pass	206	(189)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
2/4/2012	Pass			

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
9/22/2014	Pass	207	(190)	

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

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Examinee: Rubino, Jessica Louise

Examinee ID: 52218237

Date of Birth: 06/29/1985

INTERPRETATION OF RESULTS

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

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

STEP 2 CLINICAL SKILLS (CS)

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

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

ANNOTATIONS APPEARING AS "NOTE"

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

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

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

03/2015

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

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:2/13/2018

PRACTITIONER INFORMATION

Name:	Rubino, Jessica Louise
DOB:	6/29/1985
Medical School:	Southern Illinois University School Of Medicine Springfield, Illinois, UNITED STATES
Year of Grad:	2012
Degree Type:	MD
NPI:	1376982777

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
DC	MD045920			1/29/2018
MICHIGAN	4301111191	10/14/2016	1/31/2018	10/17/2017
TEXAS	BP10051026	7/1/2014	8/24/2016	2/2/2018
TEXAS	R1121	12/16/2016	2/28/2019	2/2/2018

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:2/13/2018
Practitioner Name:	Rubino, Jessica Louise	

ABMS® CERTIFICATION HISTORY

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

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	11/18/2016		02/15/2018	Initial	1/25/2018

State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

6/21/2018

Dear Jessica Rubino:

This is to notify you that you are now licensed to practice in the State of Ohio. The Board approved your request and your license number **25.000383** was issued on 06/21/2018 and will expire on 04/01/2020.

Below is a printable wallet card for your convenience. A wall certificate will be mailed to you within the next five business days. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://med.ohio.gov or by going to https://elicense.ohio.gov. These websites are updated immediately to reflect license status.

Questions concerning licensure or renewal can be sent to med.license@med.ohio.gov or med.renewal@med.ohio.gov.

Sincerely,

State Medical Board of Ohio
Licensure & Renewal Department

State Medical Board of Ohio

30 East Broad Street, 3rd Floor
Columbus, OH 43215-6127
614-466-3934
www.med.ohio.gov

THE RECORDS OF THE STATE MEDICAL BOARD OF OHIO INDICATE THAT YOU HOLD THE FOLLOWING ACTIVE LICENSE:

25.000383
Jessica Rubino

Effective Date: 06/21/2018
Expiration Date: 04/01/2020