MD

35-8-40/110
6-15-82
180.00 Spokeshts
Re
690

STATE MEDICAL BOARD OF OHIO

APPLICATION FOR MEDICAL OR OSTEOPATHIC LICENSURE
(ALL RESPONSES MUST BE TYPED)

'82 JUN 16 AM 10 21
OHIO STATE MEDICAL BOARD

SECTION 1: Identification Information- Answer All Questions

1. Present Legal Name: Dunn (last) Margaret (first) M. (middle) maiden (if applicable)

2. Address: 303 E. 37th St. #5N (street & number)
New York, (city) NY (state) 10016 (zip code) USA (country)

Intended place of practice: Dayton, (city) Ohio (state) USA (country)

Telephone: Business (212) 920-5321 (area code) Home: (212) 889-1830 (area code)

4. Place of Birth: Freeport, (city) NY (state) USA (country) Date of Birth: 9/8/54 mo. day year

5. *Sex: Male ( ) Female (X) *Optional: For statistical purposes only.

6. Physical description:
Color of Hair Light Brown Color of Eyes Blue Height 5' 2''
Build Normal Marks None Weight 110

7. Immigration or citizenship status:
Indicate which of the following documents you currently possess.

X U.S. Birth Certificate

___ Certificate of Naturalization
Number___ Date Issued___ City/State___

___ Declaration of Intention (issued by the U.S. District Court)
Number___ Date Issued___ City/State___

___ Alien Registration Receipt Card (issued by Dept. of Immigration & Naturalization)
Number___ Date Issued___ City/State___

___ Approved Petition for Immigrant Visa (issued by Dept. of Immigration & Naturalization)
Number___ Date Issued___ City/State___

___ Other, specify___

Dunn, Margaret M.

8. List all names other than the name given above that you have used. Also indicate the time period during which you used the names. Be sure to include all names. Failure to do so may result in denial. You must supply the appropriate legal document which authorizes the name change. This may be a court decree or a marriage certificate. Any document in a foreign language must be accompanied by an official, certified translation (original) as outlined in Paragraph (A)(8), Page 1 of General Instructions above.

NOTE: Individuals who retain their maiden name or hyphenate their maiden and married name are requested to be consistent in such usage.

___
Name used from: mo./yr. to mo./yr.

___
Name used from: mo./yr. to mo./yr.

SECTION 2: Educational Background

1. Preliminary Education- Census Blank
You must complete the enclosed census blank in order to apply for your preliminary education number as required by Ohio law.

2. List the names of all medical schools attended, the complete addresses, your date of graduation, and the degree that you received. Give the exact degree that appears on your diploma (M.D., D.O., M.B., B.S., M.B., B.Ch., etc.)

name	address	From: mo/day/yr	To: mo/day/yr	degree
Jefferson Medical College	Philadelphia, Pa. 19107	9/73	6/77	M.D.

Revised 3/11/82

3. You must submit a copy of your original language diploma. If it is not in English, you must supply an original certified official translation of your medical diploma which will be returned to you. The translation must be on letterhead stationery, notarized and bear both the official seal and signature of the notary. The translation should be made by one of the following individuals or institutions:

a) a professor of languages in that language
b) a priest or cleric only in the case of Latin documents
c) a recognized translation service, in the United States, e.g., Berlitz
d) a foreign embassy or consulate authorized to certify translations
e) your medical school of graduation only in the case of your medical diploma

The translator must attest to the translation, sign, and date the translation in the presence of a notary or officer authorized to administer oaths. This translation must be submitted in addition to the notarized photocopy of your diploma in its original language.

4. Standard E.C.F.M.G. Certificate

Graduates of foreign medical schools who were not American citizens prior to entering medical school should possess a valid standard E.C.F.M.G. Certificate if they graduated after 1957. Give the number and date of your certificate if applicable.

Number_____ Date_____

5. Submit a copy of E.C.F.M.G. Certificate, if applicable.

SECTION 3: Postgraduate Training

All applicants are required to complete the chart below indicating the dates and hospitals of all postgraduate training in the U.S. Give the complete address of the hospital where you were employed. Give your position and department in which you served. Account for the percentage of your time spent in clinical and administrative duties. These two numbers should add up to 100 percent.

Date mo/yr-mo/yr	Hospital	Complete Address	Position & Department	% Clin.	% Adm.
7/77-6/82	Albert Einstein - Montefiore Hospital	Bainbridge Rd. Bronx, NY 10467	Resident Surgery	80	20

Total Number of Months in Approved* Training: _____
*Approved by LCME, AOA, or in Canada.

SECTION 4: Licensure Information- Answer All Questions

1. a) Are you a diplomate of the National Board of Medical Examiners?
Yes (X) No ( ) If so, specify year 1978
Are you a diplomate of the National Board of Examiners for Osteopathic Physicians and Surgeons?
Yes ( ) No (X) If so, specify year _____
Are you a licentiate of the Medical Council of Canada?
Yes ( ) No (X) If so, specify year _____

b) List all FLEX exams which you have taken. Indicate whether you took all three days (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial).

STATE	DATE (Mo/Yr.)				
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )

c) List all other State Board exams taken. Indicate whether you took a full (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial). Also give the month and year you took the exam.

'82 JUN 15 AM10 21

STATE	DATE (Mo/Yr.)			
_____	FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____	FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____	FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )

2. List ALL states in which you are or have been fully licensed to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number and the date it was issued. If the license is properly renewed, check YES under current. If the license was not renewed, check NO.

State	Date of Issuance	License Number	Current
New York	1978	140840	YES (X) NO ( )
_____			YES ( ) NO ( )
_____			YES ( ) NO ( )
_____			YES ( ) NO ( )
_____			YES ( ) NO ( )

3. List all foreign countries in which you hold a full right to practice medicine and surgery.

Country	Date Conferred	Is Right Currently Held? (Yes or No)
_____	_____	Yes ( ) No ( )
_____	_____	Yes ( ) No ( )

4. Field of Specialization

List the field in which you have specialized (Family Medicine, Internal Medicine, Surgery, etc.). Indicate if you are Board Certified and the countries in which you are so certified.

Field	Board Certified	Year Certified	Country
Surgery	YES ( ) NO (X)	_____	_____
_____	YES ( ) NO ( )	_____	_____

SECTION 5: General Information- Answer All Questions

Each of the following questions must be answered with a yes or a no answer. Be sure to read each question carefully. All affirmative answers must be thoroughly explained. Attach a separate sheet of paper if necessary.

1. Has any license entitling you to practice in any foreign country or in any state or territory of the United States been suspended, surrendered, or revoked? YES ( ) NO (X) If so, give:

STATE_____ DATE_____ CHARGE_____

2. Have you ever been denied licensure or application for licensure in any other state or territory for any reason? YES ( ) NO (X)

If so, specify: _____
State or country Reason Date

3. Have you ever been or are you now addicted to the use of drugs or alcohol? YES ( ) NO (X)

4. Have you ever been convicted of a violation of a federal law, state law, or municipal ordinance other than a minor traffic violation? YES ( ) NO (X)

If so, specify: _____
State or country Court Offense

_____
Date Disposition

5. Has your narcotic license ever been suspended, surrendered, or revoked? YES ( ) NO (X)

If so, specify: _____
Reason Date

6. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? YES ( ) NO (X)

If so, specify: _____
School, Hospital or Institution

_____
City/State Country

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (X)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. 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 attach separate sheets.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM
7/77-6/82	Albert Einstein-Montefiore Hospitals	Bainbridge Rd. Bronx, NY 10467	Resident Surgery	80	20

FORM 3

CERTIFICATE OF RECOMMENDATION

'82 JUN 15 AM10 21

MUST BE COMPLETED FOR ALL APPLICANTS

OHIO STATE MEDICAL BOARD

This form is to be completed by a fully licensed physician in the state in which the form is notarized. The recommending physician should be sufficiently acquainted with the applicant for at least a six month period as to be able to evaluate and recommend the applicant. No relatives can serve as recommending physician. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. 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.

I, Alexander C. Hyatt, a licensed and practicing physician in the state of
Recommending Physician

New York, affirm that Margaret M. Dunn has been known to me personally and professionally for 2 years and that he/she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as excellent

His/her command of the English language is excellent

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

His/her relationship with patients is excellent

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend Margaret M. Dunn for full licensure to practice Medicine
Applicant

in Ohio.

Mount Sinai School of Medicine New York, NY
Medical School of Graduation of Recommending Physician

Alexander Hyatt
Signature of Recommending Physician

New York
State of Licensure of Recommending Physician

Alexander C. Hyatt, M.D.
Name of Recommending Physician (Please print)

135134
License No. of Recommending Physician

1 Gustave Levy Pl. New York, NY 10029
Address of Recommending Physician

(212) 650-6934
Telephone Number (Include area code)

Subscribed and sworn to this 8th day of June, 19 82.

(SEAL)

Sally Hernandez
Notary Public

SALLY HERNANDEZ
NOTARY PUBLIC, STATE OF NEW YORK
No. 31-4524131
Qualified in New York County
Commission Expires March 30, 1984

Date Commission Expires

UPON COMPLETION, RETURN TO:

STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET
ROOM 510
COLUMBUS, OHIO 43215

FORM 3

CERTIFICATE OF RECOMMENDATION

'82 JUN 15 AM10 21

MUST BE COMPLETED FOR ALL APPLICANTS

OHIO STATE

This form is to be completed by a fully licensed physician in the state in which the form is notarized. The recommending physician should be sufficiently acquainted with the applicant for at least a six month period as to be able to evaluate and recommend the applicant. No relatives can serve as recommending physician. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. 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.

I, William A. Spohn, a licensed and practicing physician in the state of
Recommending Physician

New York, affirm that Margaret M. Dunn has been known to me personally and professionally for 7 years and that he/she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as excellent

His/her command of the English language is excellent

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

His/her relationship with patients is excellent

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend Margaret M. Dunn for full licensure to practice Medicine
Applicant

in Ohio.

Jefferson Medical College Philadelphia, Pa.
Medical School of Graduation of Recommending Physician

Wm A. Spohn
Signature of Recommending Physician

New York
State of Licensure of Recommending Physician

William A. Spohn, M.D.
Name of Recommending Physician (Please print)

134342
License No. of Recommending Physician

1 Gustave Levy Pl. New York, NY 10029
Address of Recommending Physician

(212) 650-7788
Telephone Number (Include area code)

Subscribed and sworn to this 8th day of June, 1982.

(SEAL)

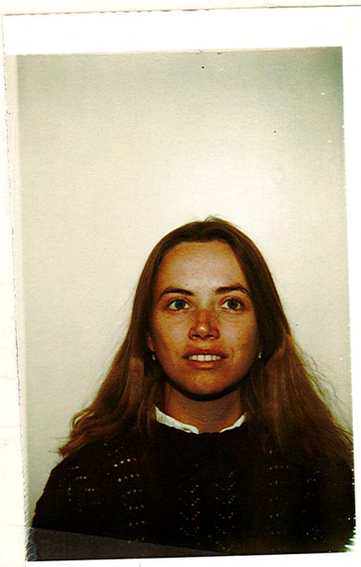
Sally Hernandez
Notary Public

SALLY HERNANDEZ
NOTARY PUBLIC, STATE OF NEW YORK
No. 31-4524131
Qualified in New York County
Commission Expires March 30, 19 84

Date Commission Expires

UPON COMPLETION, RETURN TO:

STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET
ROOM 510
COLUMBUS, OHIO 43215



SECTION 7: Examination Scheduling Request (To be completed by applicants for examination only)

1. I wish to apply for the June ( ) December ( ) _____ FLEX examination.
Fill in year

'82 JUN 15 AM 10 21

Indicate which FLEX examination you are applying to take by placing an "X" next to the appropriate month and filling in the appropriate year.

OHIO STATE MEDICAL BOARD

SECTION 8: Photograph, Photoslip, and Certificates of Recommendation (Form 3)

1. Certificates of Recommendation (Form 3) must be completed by two fully licensed physicians. The physicians must be licensed in the state in which the form is notarized. A Form 3 is enclosed for each recommending physician. Each recommending physician must also sign your photoslip as indicated below. The Certificates of Recommendation must be notarized. THE PHYSICIANS MUST HAVE KNOWN THE APPLICANT FOR AT LEAST A SIX MONTH PERIOD. NO RELATIVES CAN SERVE AS RECOMMENDING PHYSICIANS FOR FORM 3.

2. You must submit a recent color photograph. Attach the photoslip enclosed in the application to this photo. Sign and date the back of the photo and print your name. Have each of the physicians who signed your recommendation forms also sign the photoslip.

SECTION 9: Release of Applicant

STATE OF New York

COUNTY OF Bronx ss:

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the State Medical Board of Ohio any information, files, or records requested by the Board in connection with this application. I further authorize the State Medical Board of Ohio to release to the organizations, individuals, or groups listed above any information which is material to my application.

_____
(Signature of Affiant)

Subscribed and sworn to this 7 day of June, 1982

_____
(Signature of Official Administering Oath)

KATHLEEN HEATH
Notary Public, State of New York
No. 60-4715835
Qualified in Westchester County
Commission Expires March 30, 1984

(SEAL) _____
(Date Commission Expires)

Must be sworn to before a notary public or other person authorized to administer oaths.

SECTION 10: Affidavit of Applicant

STATE OF New York

COUNTY OF Bronx SS:

Before me, personally appeared Margaret M Dunn M.D.
(Affiant)

who being duly sworn says that he is the person referred to in the foregoing application for license to practice medicine and surgery or osteopathic medicine and surgery in the State of Ohio; that the statements therein and the documents or copies of documents attached thereto are strictly true in every respec and that he has read and understands this Affidavit.

_____
(Signature of Affiant)

Subscribed and sworn to this 7 day of June, 1982.

(SEAL)

_____
(Signature of Official Administering Oath)

KATHLEEN HEATH
Notary Public, State of New York
No. 60-4715835
Qualified in Westchester County
Commission Expires March 30, 1984

_____
(Date Commission Expires)

*Must be sworn to before a notary public or other person authorized to administer oaths.

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

'82 MAY 24 AM11 45

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

OHIO STATE MEDICAL BOARD

Margaret M. Dunn, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest JOHN S. MILLIS
Chairman of the Board

SEAL

EDITHE J. LEVIT
President of the Board

Philadelphia, Pa.

07/01/78

Certificate # 180478

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from JEFFERSON MEDICAL COLLEGE in JUNE 1977 and whose birth date is 09/08/1954. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/75		
Anatomy, incl. histology and embryology	665	91
Physiology	630	89
Biochemistry	660	91
Pathology	690	93
Microbiology, incl. immunology	555	84
Pharmacology and Materia Medica	570	85
Behavioral Sciences	580	86
TOTAL TEST (Minimum Passing Score 380/75)	650	89
Part II passed 09/76		
Internal medicine and the medical specialties	590	87
Surgery and the surgical specialties	600	87
Obstetrics and Gynecology	650	89
Public Health and Preventive Medicine	615	88
Pediatrics	605	87
Psychiatry	545	84
TOTAL TEST (Minimum Passing Score 290/75)	625	87
PART III passed 03/78		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	460	80.7
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		85.6

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Ann K. Heverling
Secretary for Certification

SEAL

05/19/82
Date

State of Ohio
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

'82 JUL 12 PM 2 14

OHIO STATE
MEDICAL BOARD

Federation of State Medical Boards
of the United States

JUL 08 1982

PREV. CORRES_____
ANS._____ FILE_____
CHECK_____
BY_____

Mrs. Fisher
Federation of State Medical Boards
of the United States, Inc.
2626-B West Freeway
Suite 200
Fort Worth, Texas 76102

Dear Mrs. Fisher:

The following physician has applied for endorsement licensure in Ohio:

Dunn, M.D., Margret M.

Please indicate whether you have any derogatory information in your files.
Thank you for your cooperation.

Sincerely,

Angela Albert

Angela Albert
Chief, Licensure

Derogatory Information:

Date JUL 08 1982

We have no unfavorable
information regarding
the above named physician.

Harold Jones, Jr., M.D.
Executive Director-Secretary

AA

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

'82 JUL 19 AM10 53

DATE 7/6/82

OHIO STATE MEDICAL BOARD

Dear Doctor,

Dr. Margret M. Dunn who is/was Resident/ Surgery is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 5+ years

(2) What was/is your supervisory capacity? Chairman of Dept in which she was a resident

(3) At what hospital? Montefiore Hosp & Albert Einstein Hospital

(4) How would you rate this doctor's medical knowledge and techniques? Tops

(5) In your opinion, is this doctor a person of good moral and ethical character? yes

(6) Does this doctor 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) —

(9) Would you recommend this doctor for licensure? Absolutely

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

a very outstanding physician & person. Committed, competent, ethical + with a delightful personality

Please return this form to the Ohio State Medical Board at the above address,
Sincerely,
Angela Albert
Angela Albert
Chief, Licensure

Signature of Doctor, please type or print name legibly beneath

MARVIN L. GLICKMAN

Prof + CHAIRMAN ALBERT Einstein College Med

Position + Montefiore - Med Ctr

DATE

Telephone No. 212-920-4710 (Include Area Code)

AA

State of Ohio
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

'82 JUL 27 AM 8:44

JUL 1982
LICENSING

TO: New York Medical Board

FROM: Angela Albert, Chief, Licensure

The following physician has applied for endorsement licensure in Ohio. Our files indicate that he is licensed to practice medicine in your state. Please complete the form below, and return it to this office as soon as possible since licensure is dependent upon its receipt. Thank you for your cooperation.

Name Dunn, Margaret M.

Date of Birth 9/8/54 License Number 140840 Issued 12/14/79

Is license current? yes If not, please explain _____

What is basis of license? FLEX( ) Written Exam( ) National Boards(X)
Endorsement/Reciprocity( ) Other( )

Has license been revoked, suspended or surrendered? no

Reason: _____

Derogatory Information: none

Remarks: _____

Signed Barbara J. Graham

Title Head Clerk

Date July 22, 1982

Division of Professional
Licensing Services
Cultural Education Center
Empire State Plaza
Albany, New York 12230

Omnibus has literas Visuris Salutem.

Quandoquidem **GRADUS ACADEMICI** eum in finem instituti fuerint, ut viri ingenio et doctrina præditi titulis præter cæteros insignirentur; et ut ipsis prosit, nec non aliorum provehatur industria et inter homines studium Virtutis et Bonarum Literarum augeatur: Quando etiam huc potissimum spectant amplissima illa jura nostro Collegio publico Diplomate collata. **Idcirco,**

NOTUM SIT, QUOD NOS, PRÆSES ET PROFESSORES

Collegii Medicinalis Jeffersoniani Philadelphiensis
Universitatis Thomasinae Jeffersonianae

IN REPUBLICA PENNSYLVANIENSI,

Margaret Mary Dunn Virum probum, nobis devinctissimum propter mores benevoles et omnes eas artes quæ optimum quemque ornant, qui etiam scientia eximia in Arte Medica, æque ac Chirurgica nostro Collegio sibi acquisita nobisque examinatione publice habita splenius manifesta, se dignum AMPLISSIMIS HONORIBUS ACADEMICIS ostendit, **Doctorem in Arte Medendi** creavimus et constituimus. Eique præfato Margaret Mary Dunn hujus DIPLOMATIS virtute, singula Jura Honores et Privilegia ad Gradum Doctoris in Arte Medendi inter nos et ubique gentium pertinentia libentissime et plenissime concessimus et rata fecimus.

In cujus rei fidem **HÆC MEMBRANA**, Chirographis nostris subscripta, et sigillo Universitatis nostræ munita, testimonio sit.

Datum in **URBE, PHILADELPHIA**, Decimo die Junii Anno Humanæ Salutis MCMLXXVII Annoque Rerum Publicarum Americæ Fœderatarum Summæ Potestatis Ducentesimo primo.

George M. Norwood Jr.
PRÆSES.

William F. Kellow
DECANUS, PRO PROFESSORIBUS.

TRANSLATION

DIPLOMA OF THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA
of
THOMAS JEFFERSON UNIVERSITY

TO ALL WHO SHALL SEE THESE WRITINGS, GREETING:

Forasmuch as academic degrees were instituted to the intent that persons endowed with learning and wisdom should be distinguished from others by honors, to the end that this might be profitable to them, and also that the industry of others might be stimulated and the exercise of virtue and the liberal arts be increased among mankind:-

And as the fullest rights conferred publicly by diploma in our College have this end in view:-

Therefore, be it known, that we, the President and Professors of Jefferson Medical College of Philadelphia of Thomas Jefferson University, in the Commonwealth of Pennsylvania, have created and constituted a Doctor in the Art of Healing, Margaret M. Dunn, an honorable person endeared to us by correct morals and all those virtues which adorn every good person; who also, by his/her excellent knowledge of medical as well as of surgical art, acquired by him/her in our College, and manifested more fully in an examination publicly held by us, has shown himself/herself worthy of the fullest academic honors.

To the one thus referred to, Doctor of Medicine, we have, by virtue of this diploma, most freely and fully granted and confirmed all the rights, honors and privileges belonging to the degree of Doctor in the Art of Medicine, among ourselves, and all nations.

In evidence of which let this diploma, signed in our handwriting, and having appended the seal of the University, be a testimonial.

Given in the City of Philadelphia, on the 10th day of June, in the year of human salvation 1977, and in the 201st year of the sovereign power of the United States of America.

Frank D Gray Jr

(Signatures of President and Dean)

SEAL OF UNIVERSITY

THE HOSPITAL OF THE ALBERT EINSTEIN COLLEGE OF MEDICINE
A DIVISION OF
MONTEFIORE HOSPITAL AND MEDICAL CENTER
1825 EASTCHESTER ROAD, BRONX, NEW YORK 10461 / TELEPHONE: 212-430-2000

March 29, 1982

Barbara Shoemaker
Chief, CME Records and Renewal
Ohio State Medical Board
65 South Front Street
Columbus, Ohio 43215

Dear Ms. Shoemaker:

I am currently licensed in New York. In July I will be moving to Ohio and I need the forms to apply for my license. Will you please forward them to me at my home:

Margaret M. Dunn, M.D.
303 E. 37th St.
Appt. 5N
New YOrk, NY 10016

Thank you for your attention to this matter.

Sincerely,

Margaret M. Dunn M.D.

STATE OF OHIO STATE MEDICAL BOARD

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

(SIGNATURE OF APPLICANT) 10/10/84 (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
35-04-7779

MARGARET M DUNN
381 N. FAIRFIELD ROAD
BEAVERCREEK OH 45430

OP-0345-F

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD → 60

IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS → [ ] [ ] [ ]
(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00

DATE DUE 11/15/84

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY DUE DATE.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS — IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

DUNN MARGARET M
LAST NAME FIRST NAME INITIAL

3940 Colonel Glenn Hwy 6 B
STREET ADDRESS

FAIRBORN OH 45435
CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER Redacted

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN CONVICTED OF OR PLEAD NOLO CONTENDERE TO:

YES	NO	
☐	☒	a.) a felony,
☐	☒	b.) a misdemeanor committed in the course of your practice, or
☐	☒	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO	
☐	☒	1). Been addicted to or dependent upon alcohol or any chemical substance?
☐	☒	2). Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☒	3). Surrendered or consented to limitation of license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☒	4). Had any hospital privileges suspended or revoked?

STATE MEDICAL BOARD OF OHIO

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO. THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

11/7/86

(SIGNATURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
35-04-7779

2

MARGARET M DUNN
381 N. FAIRFIELD ROAD
BEAVERCREEK OH 45430

MD & DO SPECIALTY CODES

ENTER ALL SPECIALTY CODES → 7 3 (LIMIT OF 3)

(SEE LIST ON ENCLOSED CARD)

AMOUNT DUE $100.00

DATE DUE 11/15/86

EDM-14046

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO:

TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 15

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS – IF DIFFERENT FROM THAT SHOWN ON FRONT

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER Redacted

EDM-14946-B

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☑	a.) a felony.
☐	☑	b.) a misdemeanor committed in the course of your practice, or
☐	☑	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO	
☐	☑	1.) Been addicted to or dependent upon alcohol or any chemical substance?
☐	☑	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☑	3.) Surrendered or consented to limitation upon license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☑	4.) Had any hospital privileges suspended or revoked?

STATE MEDICAL BOARD OF OHIO

MEDICINE

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

(SIGNAURE OF APPLICANT) 10/15/88 (DATE)

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. UPDATE SPECIALTY IF NEEDED.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438, COLUMBUS, OHIO 43216

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A; DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-04-7779

MARGARET M DUNN
381 N. FAIRFIELD ROAD
BEAVERCREEK OH 45430

QT-00223-OF

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME | FIRST NAME | INITIAL

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD 75

IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00

DATE DUE 11/01/88

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 1

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS – IF DIFFERENT FROM THAT SHOWN ON FRONT

(PLEASE PRINT)

DUNN MARGARET M

LAST NAME FIRST NAME INITIAL

3410 Colonel Glenn Highway

STREET ADDRESS

Dayton OH 45435

CITY STATE ZIP CODE

Greene

COUNTY

SOCIAL SECURITY NUMBER Redacted

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☒	a.) a felony
☐	☒	b.) a federal or state law regulating the possession, distribution or use of any drug?

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

YES	NO	
☐	☒	1.) Been addicted to or dependent upon alcohol or any chemical substance? 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 Section 4731.224, O.R.C., and related provisions, or are currently enrolled in a Board approved program.
☐	☒	3.) Surrendered or consented to limitation upon a license to practice medicine in this state or federal privileges to prescribe controlled substances?
☐	☒	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

...disciplinary action taken or initiated against you by a

CT-00324-08

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 DURING THE LAST BIENNIUM 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 _____ 10/2/90

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-04-7779	$160.00	11/01/90

MARGARET M DUNN, M.D.
381 N. FAIRFIELD ROAD
BEAVERCREEK OH 45430

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

73 SURGERY, GENERAL

PROCESS ☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

:969696962: 0935047779 :00000160000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

3646 COLONEL GLENN HGWY
Street

Street

DAYTON | OH | 45435
City | *State* | *Zip Code*

GREENE
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLEAD GUILTY OR NO CONTEST TO :

YES	NO	
☐	☑	*A.) A felony*
☐	☑	*B.) A federal or state law regulating the possession, distribution or use of any drug?*

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

YES	NO	
☐	☑	*1.) Been addicted to or dependent upon alcohol or any chemical substance? 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 section 4731.224, 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.*
☐	☑	*2.) Had any disciplinary action taken or initiated against you by any state licensing board?*
☐	☑	*3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?*
☐	☑	*4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?*

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 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM 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 _____ 6/5/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-7779	$160.00	07/01/92

MARGARET M DUNN,M.D.
381 N. FAIRFIELD ROAD
BEAVERCREEK OH 45430

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

73 SURGERY, GENERAL

PROCESSED [illegible]

☒ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935047779" :"00000160000:"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

30 E APPLE ST. STE 5250
Street

~~DAYTON~~
Street

DAYTON OH 45409
City State Zip Code

MONTGOMERY
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NO CONTEST TO :

YES NO

☐ ☒ A.) A felony or misdemeanor.

☐ ☒ B.) A federal or state law regulating the possession, distribution or use of any drug?

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

YES NO

☐ ☒ 1.) 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 section 4731.224, 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

☐ ☒ 2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO

☐ ☒ 3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO

☐ ☒ 4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

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 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 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY 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 _____ 5/19/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35047779	$250.00	05/01/94

MARGARET M DUNN,M.D.
381 N FAIRFIELD ROAD
BEAVERCREEK OH 45430

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GS GENERAL SURGERY

☐ 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

:96969696 2: 0935047779" "00000 25000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

30 APPLE ST
Street

STE 5250
Street

DAYTON | OH | 45409
City | State | Zip Code

MONTGOMERY
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 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.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

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

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

YES ☐ NO ☑ 8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

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 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 1994-1996 BIENNIUM 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 _____ 3/25/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-7779	$250.00	05/01/96

MARGARET M ~~DEVITT~~ Dunn, M.D.
381 N FAIRFIELD ROAD
BEAVERCREEK OH 45430

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GS GENERAL SURGERY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

1 WYOMING ST STE 7000
STREET
STREET
DAYTON OH 45409
CITY STATE ZIP CODE
MONTGOMERY
COUNTY

:969696962: 0935047779 00000 25000

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

30 E Apple St
Street

Street

Dayton | OH | 45469
City | State | Zip Code

Montgomery
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 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.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO

☐ ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO

☐ ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO

☐ ☑ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

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 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 1996-1998 BIENNIUM 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 _____ 3/3/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-7779-D	$339.00	05/01/98

MARGARET M DUNN,M.D.
1 WYOMING STREET
SUITE 7000
DAYTON OH 45409

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GS GENERAL SURGERY

☒ 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: 0935047779" "0000033900"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

30 E APPLE ST
Street

SUITE 5253
Street

DAYTON OH 45409
City State Zip Code

County

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

YES [ ] NO [X] 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES [ ] NO [X] 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 [X] 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 [X] 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES [ ] NO [X] 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES [ ] NO [X] 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES [ ] NO [X] 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES [ ] NO [X] 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

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 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 _____ 10/16/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-7779-D	$305.00	01/01/2001

MARGARET M DUNN,M.D.
1 WYOMING STREET
SUITE 7000
DAYTON OH 45409

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GS GENERAL SURGERY

☑ 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.

STREET

STREET

CITY STATE ZIP CODE

COUNTY

:96969696 2: 0935047779 0000030500

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ *Check this Box if you have NO principle Practice address.*

Street

Street

City *State* *Zip Code*

County

AT ANY TIME SINCE SIGNING YOUR LAST 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 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*

☐ ☐ *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 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?***

REQUIRED:

SOCIAL SECURITY NUMBER

State Medical Board of Ohio

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

Date: November 15, 2000

MARGARET M. DUNN, M.D.
1 WYOMING STREET
SUITE 7000
DAYTON, OH 45409

Please be advised that in reviewing your renewal application card for your Ohio license, we find that you failed to answer the following question(s). To continue processing your renewal, answer each checked question below:

	AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE: (only those questions marked with a ✓ apply to you)	YES	NO
☐	1.) *Have you been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a or misdemeanor or felony?*	☐	☐ ✓
☐	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 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.*	☐	☐ ✓
☐	3.) *Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?*	☐	☐ ✓
☐	4.) *Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints filed against you?*	☐	☐ ✓
☐	5.) *Have you surrendered, or consented to limitation of 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.*	☐	☐ ✓
☐	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?***	☐	☐ ✓
☐ ✓	**YOU DID NOT ANSWER ANY OF THE QUESTIONS. ANSWER EACH QUESTION (1 - 7) ABOVE.**		

OVER ⇨

I certify, that the information provided is true and correct.

Signature of Applicant

11/30/00
Date

Upon completion of this form, return directly to the Board. If your response is not received in this office by your date of expiration, your Ohio license will lapse by action of law.

Should you have any questions concerning this information, please contact me at the address indicated on the other side.

Sincerely,

Debra L. Jones, Chief
C.M.E., Records and Renewal

DLJ:jdc

Date Posted: 10/31/2004

License Number	35.047779
License Name	MARGARET DUNN
Email Address	

Fees

Relicensure Fee	$305.00
Late Fee	$0.00
Online Renewal Surcharge	$0.00
	==========
Total Fees	**$305.00**

Address Information Section

BUSINESS ADDRESS	30 E APPLE ST SUITE 5253 DAYTON, OH 45409 Montgomery County
CREDENTIAL MAIL ADDRESS	381 N FAIRFIELD RD DAYTON, OH 45430 Greene County
MAIN	381 N FAIRFIELD RD DAYTON, OH 45430 Greene County

Specialty Codes Section

1. Please select one specialty from the field below

. . . . . GENERAL SURGERY

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 Section

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

. . . . . YES

Discipline Section

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 Section

1.

. . . . . Redacted

Nurs

Date Posted: 10/4/2006 1:00:16 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	35.047779
License Name	MARGARET DUNN
Email Address	margaret.dunn@wright.edu

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . GENERAL SURGERY

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: 10/29/2008 8:46:20 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.

Address Information

CREDENTIAL MAIL ADDRESS	3640 Colonel Glenn Highway DAYTON, OH 45435-0001 Greene County
MAIN	3640 Colonel Glenn Highway DAYTON, OH 45435-0001 Greene County

License Information

License Number	35.047779
License Name	MARGARET DUNN
Email Address	margaret.dunn@wright.edu

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   . . . . . GENERAL SURGERY
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}*

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: 10/18/2010 3:02:34 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	1222 S Patterson Blvd Suite 220 Dayton, OH 45402 Montgomery County United States of America (937) 424-2469 margaret.dunn@wright.edu
CREDENTIAL MAIL ADDRESS	3640 Colonel Glenn Highway DAYTON, OH 45435-0001 Greene County United States of America (937) 775-2033 margaret.dunn@wright.edu
MAIN	152 E Limestone St Yellow Springs, OH 45387 Greene County United States of America (937) 767-0158 margaret.dunn@wright.edu

License Information

License Number	35.047779
License Name	MARGARET DUNN

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

. . . . . GENERAL SURGERY

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

. 10-14

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.)

. 30-34

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

. 5-9

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

. 1-4

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

. 0

Clinical - Practice setting

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

. 5-9

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

. 5-9

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 45402

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. 45409

4. Enter the second county:

. . . . . *{not Answered}*

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

. . . . . N/A

3. Multi-specialty Group

. . . . . 10+

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?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Surgery

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.

Date Posted: 10/8/2012 1:41:14 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 35.047779

License Name MARGARET DUNN

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

. . . . . GENERAL SURGERY

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

. 10-14

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.)

. 30-34

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

. 5-9

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

. 1-4

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

. 1-4

Clinical - Practice setting

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

. 5-9

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

. 5-9

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 45402

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . 10+

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?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Surgery

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.

Date Posted: 10/6/2014 3:39:37 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	2300 Miami Valley Dr Suite 350 Dayton, OH 45459 Montgomery County United States of America (937)424-2469 margaret.dunn@wright.edu
CREDENTIAL MAIL ADDRESS	Wright State Dept of Surgery 128 E Apple St Suite 7816 Dayton, OH 45409 Montgomery County United States of America (937)208-2951 margaret.dunn@wright.edu
MAIN	152 E Limestone St Yellow Springs, OH 45387 Greene County United States of America (937)767-0158 margaret.dunn@wright.edu

License Information

License Number	35.047779
License Name	MARGARET DUNN

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

. . . . . GENERAL SURGERY

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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, 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

. 25-29

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.

. 10-14

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

. 1-4

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

. 5-9

Clinical - Practice setting

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

. 15-19

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

. 0

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

. 0

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

. 0

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

. 10-14

Workforce Counties

1. Enter the first zip code:

. 45459

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. 45409

4. Enter the second county:

. . . . . Montgomery

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. 5-10

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?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Surgery

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1700842788

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . AD9096113

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: 11/28/2016 3:53:05 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

CREDENTIAL MAIL ADDRESS

Wright State Boonshoft School of Medicine
Office of the Dean
725 University Blvd
Dayton, OH 45324
Greene County
United States
(937)245-7600
margaret.dunn@wright.edu

License Information

License Number 35.047779
License Name MARGARET DUNN

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

. . . . . GENERAL SURGERY

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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, 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

. 5-9

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.)

. 50-54

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

. 1-4

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

. 1-4

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

. 0

Clinical - Practice setting

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

. 1-4

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

. 0

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

. 0

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

. 0

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

. 1-4

Workforce Counties

1. Enter the first zip code:

. 45459

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. 45409

4. Enter the second county:

. . . . . Montgomery

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . 10+

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?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Surgery

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1700842788

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . AD9096113

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . YES

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . YES

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.

Submission Date and Time: 1/8/2019 3:10 PM

License Renewal Application

License Type - Doctor of Medicine (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. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

Title
Dr.
First Name
MARGARET
Middle Name
M
Last Name
DUNN
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
9/8/1954
Email Address
margaret.dunn@wright.edu
Phone Number
(937) 424-2469
Other Phone Number
(937) 208-2552
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No Response
What do you consider your race?
No Response
List languages you personally use to communicate with patients excluding an interpreter or software
No Response
Other Language
No Response
Individual National Provider Identifier - if not applicable leave blank
1700842788
Enter home US zip-code. Enter NA if unavailable
45387

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?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
New York
In which city were you born?
Centerville

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Leave the field associated with this license

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.

725 University Blvd Office of the Dean
Dayton
OH
45324
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.

2300 Miami Valley Dr
Centerville
OH

45459-4779
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
If you answered "Yes", are you currently serving in the military?
No
Has your spouse served in the military?
Yes
If you answered "Yes", are they currently serving in the military?
No
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

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 - Surgery
Medical SubSpeciality - null

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position

that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Wright State Surgery
Practice Settings - Medical School
Street Address - 30 E Apple St
City - Dayton
State - OH
Zip Code - 45409
Major Area of Focus or Specialty - Surgery
Total Hours Worked at this practice site, per Week - 1

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 100
Teaching/Academic - 0
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - No

Name of Practice Site - Wright State Surgery
Practice Settings - Medical School
Street Address - 2300 Miami Valley Dr
City - Centerville
State - OH
Zip Code - 45459
Major Area of Focus or Specialty - Surgery
Total Hours Worked at this practice site, per Week - 8

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 70
Teaching/Academic - 30
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Salaried
Other Employment Arrangement - null

Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - Yes

Name of Practice Site - Wright State Boonshoft School of Medicine
Practice Settings - Medical School
Street Address - 725 University Blvd
City - Dayton
State - OH
Zip Code - 45435
Major Area of Focus or Specialty - Surgery
Total Hours Worked at this practice site, per Week - 50

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 0
Teaching/Academic - 20
Research - 5
Professional Services - 0
Administrative Activities - 75
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - No
Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - No

Questions

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

Question - At any time since signing your last application for renewal of your certificate have you ever been denied a license to prescribe, dispense, administer, supply, or sell a controlled substance by the drug enforcement administration or appropriate issuing body of any state or jurisdiction, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever had a restriction of a license issued by the drug enforcement administration or a state licensing administration in any jurisdiction, under which you could prescribe, dispense, administer, supply or sell a controlled substance, that was restricted, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying, or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever been subject to disciplinary action by any licensing entity that was based, in whole or in part, on inappropriate

prescribing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - Have you completed at least two hours of continuing medical education, annually for the past two years, that were certified by the Ohio State Medical Association or the Ohio Osteopathic Association, that assist physicians in diagnosing qualifying medical conditions and treating these conditions with medical marijuana including the characteristics of medical marijuana and possible drug interaction.
Answer -
Question - At any time since signing your last application for renewal of your certificate do you have an ownership or investment interest in or compensation agreement with any medical marijuana entity or applicant?
Answer -
Question - At any time since signing your last application for renewal of your certificate 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?
Answer - No

Question - At any time since signing your last application for renewal of your certificate 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?
Answer - No

Question - At any time since signing your last application for renewal of your certificate 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?
Answer - No

Question - At any time since submission of your last application for renewal 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.
Answer - No

Question - At any time since signing your last application for renewal of your certificate 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?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

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

Answer - No

Question - Do you currently supervise one or more Physician Assistants?
Answer - No

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

Question - Primary DEA Number
Answer - AD9096113

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

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.

Review + Submit

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

Application Review - Completed

Attestation

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.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 1/8/2019 3:10 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
MARGARET DUNN
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.

Contact Audit Trail for DUNN MARGARET

Date	User	Table	Field	New	Old
1/9/2017 11:09:26 AM	Rieve, K	CONTACTADDRESS	ADDRESS1	725 University Blvd	Wright State Boonshoft School of Medicine
1/9/2017 11:09:26 AM	Rieve, K	CONTACTADDRESS	COMPANY	Wright State Boonshoft School of Medicine	
1/9/2017 11:09:26 AM	Rieve, K	CONTACTADDRESS	ADDRESS3		725 University Blvd
11/28/2016 4:13:29 PM	Bates, J	CONTACTADDRESS	COUNTYID	Greene	Montgomery
11/28/2016 4:13:29 PM	Bates, J	CONTACTADDRESS	ADDRESS3	725 University Blvd	Suite 7816
11/28/2016 4:13:29 PM	Bates, J	CONTACTADDRESS	PHONE	(937)245-7600	(937)208-2951
11/28/2016 4:13:28 PM	Bates, J	CONTACTADDRESS	ADDRESS2	Office of the Dean	128 E Apple St
11/28/2016 4:13:28 PM	Bates, J	CONTACTADDRESS	ZIPCODE	45324	45409
11/28/2016 4:13:28 PM	Bates, J	CONTACTADDRESS	ADDRESS1	Wright State Boonshoft School of Medicine	Wright State Dept of Surgery
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	COUNTYID	Montgomery	Greene
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	ADDRESS3	Suite 7816	
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	ZIPCODE	45459	45402
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	ZIPCODE	45409	45435-0001
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	PHONE	(937)767-0158	9377670158
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	PHONE	(937)424-2469	9374242469
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	PHONE	(937)208-2951	9377752033
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	ADDRESS2	Suite 350	Suite 220
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	ADDRESS2	128 E Apple St	
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	ADDRESS1	2300 Miami Valley Dr	1222 S Patterson Blvd
10/6/2014 4:24:19 PM	Bates, J	CONTACTADDRESS	ADDRESS1	Wright State Dept of Surgery	3640 Colonel Glenn Highway
10/18/2010 3:18:03 PM	Moore, A	CONTACTADDRESS	COUNTRYIDNT	United States of America	
10/18/2010 3:18:03 PM	Moore, A	CONTACTADDRESS	COUNTRYIDNT	United States of America	
10/18/2010 3:18:03 PM	Moore, A	CONTACTADDRESS	COUNTRYIDNT	United States of America	
10/18/2010 3:18:02 PM	Moore, A	CONTACTADDRESS	PHONE	9377670158	
10/18/2010	Moore, A	CONTACTADDRESS	PHONE	9374242469	

3:18:02 PM					
10/18/2010 3:18:02 PM	Moore, A	CONTACTADDRESS	PHONE	9377752033	
10/18/2010 3:18:02 PM	Moore, A	CONTACTADDRESS	CITY	Yellow Springs	DAYTON
10/18/2010 3:18:02 PM	Moore, A	CONTACTADDRESS	ZIPCODE	45387	45435-0001
10/18/2010 3:18:02 PM	Moore, A	CONTACTADDRESS	ZIPCODE	45402	45409
10/18/2010 3:18:02 PM	Moore, A	CONTACTADDRESS	ADDRESS2	Suite 220	SUITE 5253
10/18/2010 3:18:02 PM	Moore, A	CONTACTADDRESS	ADDRESS1	152 E Limestone St	3640 Colonel Glenn Highway
10/18/2010 3:18:02 PM	Moore, A	CONTACTADDRESS	ADDRESS1	1222 S Patterson Blvd	30 E APPLE ST
10/29/2008 3:51:27 PM	Jones, D	CONTACTADDRESS	ZIPCODE	45435-0001	45430
10/29/2008 3:51:27 PM	Jones, D	CONTACTADDRESS	ZIPCODE	45435-0001	45430
10/29/2008 3:51:27 PM	Jones, D	CONTACTADDRESS	ADDRESS1	3640 Colonel Glenn Highway	381 N FAIRFIELD RD
10/29/2008 3:51:27 PM	Jones, D	CONTACTADDRESS	ADDRESS1	3640 Colonel Glenn Highway	381 N FAIRFIELD RD