02061-12782

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

MD

FOR BOARD USE ONLY
BK:_____ PG:_____ LN:_____
DATE: 7/17/03 FEE: **$335.00** PMT: 652

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

☐ Check here if you wish to apply for a Telemedicine certificate

IDENTIFICATION

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50. O.R.C.) It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760. or 4762., O.R.C. or as otherwise required by state or federal law.

U.S. Social Security Number	Redacted			
Full Name (Use no initials)	Last (Surname): Hackney	First: David	Middle: Nicholas	Suffix (Jr., II):
Name (As you prefer it inscribed on your Ohio license)	Last (Surname): Hackney	First: David	Middle: Nicholas	Suffix (Jr., II):
Maiden Name or Other Names Used (If none, enter "NONE")	Last (Surname):	First:	Middle:	Suffix (Jr., II):

Current Home Address IMPORTANT Notify the Board office immediately in writing of any change in address	Number and Street: 298 E. Whittier St.			Apt.:
	City: Columbus	State: OH	Zip Code: 43206	Country: USA

Telephone Number	Area Code & Number — Business: ( )	Area Code & Number — Home: (614) 445-0373

Birth Date	month/day/year: 11/27/73	**Birth Place**	City: Oakland	State: CA	Country: USA
Physical Description	Height: 6'2	Weight: 220	Hair Color: Black	Eye Color: Brown	Identifying marks: None
Gender	☒ Male	☐ Female	For statistics only (optional)		

Are you or will you be in an accredited training program in Ohio? ☒ Yes ☐ No
If yes, please identify name of training program and location:

Ohio State University Medical Center — Name of Hospital/Training Program
Columbus, OH — Location
Starting Date: 6/20/00 — month/day/year

OVER ⇨

OHIO MEDICAL BOARD
JUL 10 2003

WRITTEN EXAMINATION

Indicate which licensing examination(s) you have passed:

- ☐ National Boards (MD or DO)
- ☐ FLEX (Pre-1985)
- ☐ FLEX Components 1 & 2
- ☐ State Board exam: _____ (State & Date Taken (mo/yr))
- ☒ USMLE Steps 1, 2, 3
- ☐ LMCC
- ☐ Other: explain: _____

LICENSES IN THE UNITED STATES AND CANADA

List ALL states/provinces in which you hold or have held a license to practice medicine and surgery or osteopathic medicine and surgery, including a temporary license, training certificate, educational permit, or other license or certificate, ***whether the license is current or not***. If additional space is needed, attach an extra sheet. **(If none, enter "N/A"). A Form 2, Verification of License, must be sent to each state listed.**

STATE/PROVINCE	ISSUE DATE (MO/YR)	LICENSE NO.	LICENSE CURRENT YES	LICENSE CURRENT NO	EXPIRE(S)
OH	11/00	57-003690	☐	☒	6/30/03
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

SPECIALTY BOARDS

NAME OF SPECIALTY BOARD (If none, enter "N/A")	YEAR CERTIFIED	COUNTRY

CONTINUED ⇨

FEDERATION CREDENTIALS VERIFICATION SERVICE

Ohio requires verification of your core credentials directly through the Federation Credentials Verification Service (FCVS).

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

If yes, date forwarded: 7/3/03 FCVS Packet ID Number (if known): _____

ECFMG CERTIFICATE
(International Medical School Graduates only)

ECFMG Number		Date Issued		Expiration Date	

TEST OF SPOKEN ENGLISH
(International Medical School Graduates only)

THE TOEFL, TWE, ECFMG'S ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 40 (230 if taken prior to 7/95) on the Educational Testing Services Test of Spoken English (TSE), regardless of citizenship or country of birth, unless you meet one of the following:

	YES	NO
Have you completed two years of undergraduate college work in the United States?	☐	☐
Have you held a current medical license in the United States **AND** have you been actively practicing medicine in the United States for the **last five years**?	☐	☐
Have you been participating in a graduate medical education program and since that time held an unrestricted license and actively practiced medicine in the United States for **the last five years**?	☐	☐
Have you completed a Fifth Pathway program?	☐	☐
Have you passed the Clinical Skills Assessment examination given by ECFMG on or after July 1, 1998?	☐	☐

If you answered **NO** to all of the above questions you **must** take the TSE. Refer to the application instructions for contacting the Educational Testing Service. The Board cannot waive this requirement.

RESUME OF ACTIVITIES - MEDICINE OR OSTEOPATHIC MEDICINE

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

From / To	Hospital, University or Other / Complete Street Address / City / State/Country / Zip Code	Position & Department	% Clinical / % Admin.
From Month/Year 6/00 To Month/Year present	OhioState University Medical Center 456 W 10th Street Columbus OH 43210	Resident Ob/Gyn	100
From Month/Year / To Month/Year /			
From Month/Year / To Month/Year /			
From Month/Year / To Month/Year /			
From Month/Year / To Month/Year /			

OVER ⇨

ADDITIONAL INFORMATION
MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

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

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

OVER ⇨

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☒
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☒
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☒
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☒
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☒
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☒
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☒
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☒
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☒

CONTINUED ⇨

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	☐	☒
22.	a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☒
	b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☒
	If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **<u>You may answer "NO" to this question if</u>** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.	☐	☒
	a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?	☐	☐
	If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		
	b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☐

OVER ⇨

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☒
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☐
	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☐

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☒
	a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.	☐	☐

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **This form must be notarized by the recommending physician**. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Philip Samuels, MD (recommending physician, print name), a licensed and practicing physician in the state of Ohio (state of residence),

affirm that David N Hackney (applicant, print name) has been known to me personally for 3 years

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: Excellent
- His/her relationship with patients is: Excellent
- I rate his/her ability to work well with peers and medical staff as: Excellent
- His/her command of the English language is: Excellent
- Additional comments: _____

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 1654 Upham Dr. 5th Floor City: Columbus, State: OH, Zip Code: 43210	Telephone Number (include area code)	614-293-3773
Signature of Recommending Physician (name stamps not acceptable)	Philip Samuels	State of Licensure & License Number	35-06-4165-J

Signature of Applicant: David Hackney

Date Photo Taken: 7 / 03 (Mo/Yr)

Subscribed and sworn to before me this 10th day of July, 2003.

Tracy L Janosik
Notary Public Signature

4-1-06
Date Commission Expires

NOTARIAL SEAL
STATE OF OHIO

NOTARY SEAL
TRACY L. JANOSIK
Notary Public, State of Ohio
My Commission Expires 04-01-06

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

JUL 15 2003

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **This form must be notarized by the recommending physician**. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return directly to the State Medical Board of Ohio at the above address.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, JAY JAMS, M.D. (recommending physician, print name), a licensed and practicing physician in the state of OHIO (state of residence),

affirm that David Hackney (applicant, print name) has been known to me personally for 4 years

and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: Excellent
- His/her relationship with patients is: Excellent
- I rate his/her ability to work well with peers and medical staff as: Excellent
- His/her command of the English language is: Excellent
- Additional comments:

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: DEPT OF OB/GYN-OSU City: COLUMBUS State: OH Zip Code: 43210	Telephone Number (include area code)	614-293-8736
Signature of Recommending Physician (name stamps not acceptable)	[signature]	State of Licensure & License Number	OH 41079

Signature of Applicant

Date Photo Taken: 7/03 (Mo/Yr)

Subscribed and sworn to before me this 15th day of July, 2003.

Notary Public Signature

4-1-06

Date Commission Expires

NOTARY SEAL
TRACY L. JANOSIK
Notary Public, State of Ohio
My Commission Expires 04-01-06

OK
8/14/03 KAR

20611

83363

MEDICINE OR OSTEOPATHIC MEDICINE
PRELIMINARY EDUCATION FORM

TO BE COMPLETED BY ALL APPLICANTS

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	Hackney	David	Nicholas	

High School or Equivalent

School Name: North Allegheny (Pittsburgh)
City: | State: PA | Country: USA

Dates Attended From: MO/YR 8 '88 To: MO/YR 5 '92

Undergraduate College or Equivalent

School Name: Carnegie Mellon University
City: Pittsburgh | State: PA | Country: USA

Dates Attended From: MO/YR 8 '92 To: MO/YR 5 '96 | Degree Received: BA

School Name:
City: | State: | Country:

Dates Attended From: MO/YR / To: MO/YR / | Degree Received:

Medical or Osteopathic School of Graduation

School Name: University of Pittsburgh School of Medicine
City: Pittsburgh | State: PA | Country: USA

Dates Attended From: MO/YR 8 '96 To: MO/YR 5 '00 | Degree Received: MD

FOR BOARD USE ONLY

OHIO MEDICAL BOARD
JUL 10 2003

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 104068 DATE ISSUED: SEP 12 2003

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

Kay Kreve
Entrance Examiner

Secretary

AFFIDAVIT AND RELEASE OF APPLICANT
MEDICINE OR OSTEOPATHIC MEDICINE

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

ss STATE OF: Ohio

COUNTY OF: Franklin

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

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

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

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change occurs at any time prior to a license to practice medicine or osteopathic medicine being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a license to practice medicine or osteopathic medicine and that any fee I submitted is neither refundable nor transferable.

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

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

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

David Hackney
Signature of Applicant

Subscribed and sworn to before me this 8th day of July 2003.

(NOTARY SEAL) **Sarah A. Bourne**
Notary Public
In and for the State of Ohio
My Commission Expires
January 6, 2007

Sarah A. Bourne
Signature of Notary Public

Date Commission Expires

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**David Nicholas Hackney**
SSN:	Redacted
DOB:	**11/27/1973**
Recipient:	**State Medical Board of Ohio**

NOTICE:

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

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

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**David Nicholas Hackney**	
Other Name Used:	**N/A**	
Gender:	**Male**	
Date of Birth:	**11/27/1973**	
Place of Birth:	**Oakland, CA USA**	
SSN:	Redacted	
Current Address:	**298 East Whittier Street** **Columbus, OH 43206**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**614-293-4532**
	Fax:	**614-293-5877**
	Home:	**614-445-0373**
	Other:	**614-730-6943**
Physical Description:	Height:	**6' 02"**
	Weight:	**230 lbs**
	Eye Color:	**Hazel**
	Hair Color:	**Black**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

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

Institution:	**Carnegie Mellon University, Pittsburgh, PA 15213**
Dates of Attendance:	**08/1992 - 05/1996**
Degree Awarded:	**Bachelor of Arts**

Medical Education:

Current, valid ECFMG	**N/A**
ECFMG Number:	**N/A**
Date Issued:	**N/A**
Medical School:	**University of Pittsburgh School of Medicine** **G3 Thackeray Hall** **139 University Place** **Pittsburgh, PA 15260**
Dates of Attendance:	**08/19/1996 - 05/18/2000**
Graduation Date:	**05/27/2000**
Degree Awarded:	**Doctor of Medicine**

Unusual Circumstance: **None**

Post Graduate Medical Education:

Institution: **Ohio State University Hospital**
Department of Obstetrics and Gynecology
1654 Upham Drive
507 Means Hall Fifth Floor
Columbus, OH 43210-1228

Post Graduate Year: **1**
Program Type: **Residency**
Department: **Obstetrics and Gynecology**
Dates of Attendance: **07/01/2000 - 06/30/2001**
Completion: **Yes**
Accreditation: **ACGME**

Post Graduate Year: **2-4**
Program Type: **Residency**
Department: **Obstetrics and Gynecology**
Dates of Attendance: **07/01/2001 - 06/30/2004**
Completion: **Yes**
Accreditation: **ACGME**

Unusual Circumstance: **None**

Fifth Pathway:

N/A

Examination History:

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

Board Action:

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

Omission / Discrepancy Report

Physician Identification:

Name:	David Nicholas Hackney
DOB:	11/27/1973
SSN:	Redacted
Packet ID:	33816
Request ID:	11380283

REPORT OF OMISSIONS

There are none identified.

REPORT OF DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Examination History**
Discrepancy:	The applicant reports sitting for USMLE Step 1 in 05/1998. The USMLE transcript reports the examination date was 06/09/1998.
Follow-Up:	Left to Recipient`s discretion.

MISCELLANEOUS INFORMATION

There are none identified.

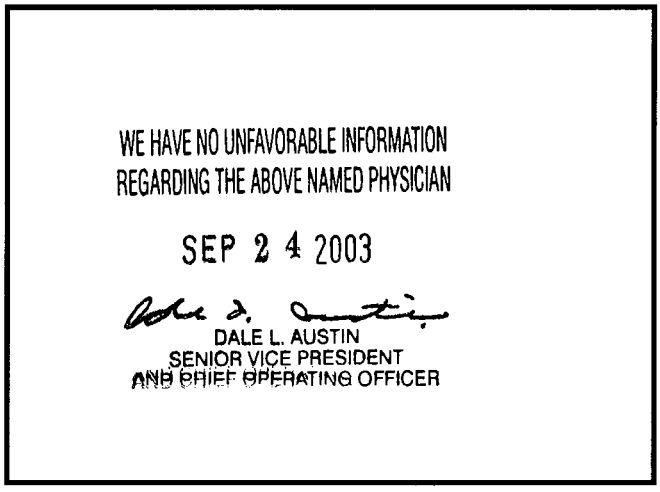
End of report for David Nicholas Hackney

Packet Id: 33816 Request Id: 11380283 Report Created By: MKV

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name:	**Hackney, David Nicholas**
Date of Birth:	**11/27/1973**
Medical School:	**039070 - Univ Pittsburgh Sch Med**
Year of Graduation:	**2000**
Social Security Number:	Redacted
ECFMG Number:	**N/A**

Results:



Section II

Identity

AFFIDAVIT AND RELEASE

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

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

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

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

David N Hackney

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

Hackney

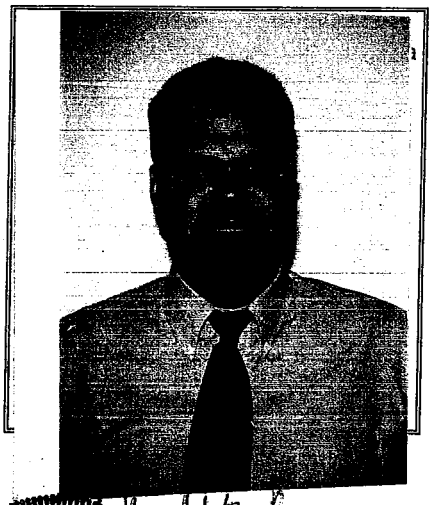
Applicant's **Printed** Last Name

David N Hackney

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

7/8/03

Date of Signature (must correspond to date of notarization)



NOTARIAL SEAL STATE OF OHIO

Sarah A. Bourne
Notary Public
In and for the State of Ohio
My Commission Expires
January 6, 2007

State of Ohio, County of Franklin

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 8th day of July, 2003.

Notary Public signature: Sarah A. Bourne

My commission expires: _____

Notary:
The Physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

Federation Credentials Verification Service

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

OFFICE OF RECORDER

COUNTY OF ALAMEDA

OAKLAND, CALIFORNIA

104-73-235859 (STATE BIRTH CERTIFICATE NUMBER)

CERTIFICATE OF LIVE BIRTH

STATE OF CALIFORNIA—DEPARTMENT OF PUBLIC HEALTH

6015 11471 (LOCAL REGISTRATION DISTRICT AND CERTIFICATE NUMBER)

THIS CHILD

1a. NAME OF CHILD—FIRST NAME	1b. MIDDLE NAME	1c. LAST NAME
DAVID	NICHOLAS	HACKNEY

2. SEX	3a. THIS BIRTH (SINGLE, TWIN OR TRIPLET)	3b. IF TWIN OR TRIPLET, THIS CHILD BORN 1ST, 2ND, 3RD	4a. DATE OF BIRTH—MONTH, DAY, YEAR	4b. HOUR
Male	Single	-	November 27, 1973	2:45 A

PLACE OF BIRTH

5a. PLACE OF BIRTH—NAME OF HOSPITAL	5b. STREET ADDRESS (STREET AND NUMBER, OR LOCATION)	5c. INSIDE CITY CORPORATE LIMITS (SPECIFY YES OR NO)
Kaiser Foundation Hospital 08	280 West MacArthur Blvd.	Yes

5d. CITY OR TOWN	5e. COUNTY
Oakland	Alameda

MOTHER OF CHILD

6a. MAIDEN NAME OF MOTHER—FIRST NAME	6b. MIDDLE NAME	6c. LAST NAME (MARRIED SURNAME)	7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Deborah	Ann	Perreand	Louisiana

8. AGE OF MOTHER (AT TIME OF THIS BIRTH)	9a. SOCIAL SECURITY NUMBER OF MOTHER	9. COLOR OR RACE OF MOTHER	10a. RESIDENCE OF MOTHER—STREET ADDRESS (STREET AND NUMBER, RURAL ROUTE NUMBER OR LOCATION)	10b. INSIDE CITY CORPORATE LIMITS (SPECIFY YES OR NO)
25 YEARS	Not Known	Caucasian	1118 8th Street #D	Yes

10c. RESIDENCE OF MOTHER—CITY OR TOWN	10d. RESIDENCE OF MOTHER—COUNTY	10e. RESIDENCE OF MOTHER—STATE
Albany	Alameda	California

FATHER OF CHILD

11a. NAME OF FATHER—FIRST NAME	11b. MIDDLE NAME	11c. LAST NAME	12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
David	Daniel	Hackney	Louisiana

13. AGE OF FATHER (AT TIME OF THIS BIRTH)	13a. SOCIAL SECURITY NUMBER OF FATHER	14. COLOR OR RACE OF FATHER	15a. PRESENT OR LAST OCCUPATION	15b. KIND OF INDUSTRY OR BUSINESS
25 YEARS	Not Known	Caucasian	Graduate Student	University of California

INFORMANT'S CERTIFICATION

I HEREBY CERTIFY THAT I HAVE REVIEWED THE ABOVE-STATED INFORMATION AND THAT IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

16a. PARENT OR OTHER INFORMANT—SIGNATURE (IF OTHER THAN PARENT, SPECIFY) ▶ Deborah Ann Hackney

16b. DATE ACCEPTED AND SIGNED BY INFORMANT: November 27, 1973

ATTENDANT'S CERTIFICATION

I HEREBY CERTIFY THAT I ATTENDED THIS BIRTH AND THAT THE CHILD WAS BORN ALIVE AT THE HOUR, DATE AND PLACE STATED ABOVE

17a. PHYSICIAN (OR OTHER PERSON WHO ATTENDED THIS BIRTH)—SIGNATURE—DEGREE OR TITLE ▶ J. Booker, M.D. J Booker M.D

17b. DATE SIGNED BY PHYSICIAN OR OTHER ATTENDANT: 12/5/73

17c. ADDRESS: 280 West MacArthur Blvd. Oakland, Calif.

17d. PHYSICIAN'S CALIFORNIA LICENSE NUMBER: House Officer

LOCAL REGISTRAR

18.

19. LOCAL REGISTRAR—SIGNATURE ▶ Martin Petrin, mgr.

20. DATE RECEIVED FOR REGISTRATION BY LOCAL REGISTRAR: DEC 10 1973

SEAL VERIFIED

1339614

CERTIFIED COPY OF VITAL RECORDS
STATE OF CALIFORNIA, COUNTY OF ALAMEDA

This is a true and exact reproduction of the document officially registered and placed on file in the office of the Alameda County Recorder.

DATE ISSUED APR 29 2003

Patrick O'Connell
PATRICK O'CONNELL
ALAMEDA COUNTY RECORDER

This copy is not valid unless prepared on an engraved border displaying the date, seal and signature of the Recorder.

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Pittsburgh School of Medicine

Complete Address: 3550 Terrace Street

Street Address:

City: Pittsburgh **State:** PA **ZIP Code (Postal Code):** 15261

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

Premedical Education:

Years of education required for admission to your medical school: four year undergraduate degree

Credential/degree presented by the applicant for admission to your medical school: Bachelor's degree

Enrollment and Participation: Our records indicate that David Nicholas Hackney
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 171 weeks of medical education on the following dates (mm/dd/yy):

From 08 / 19 / 96 (Month / Date / Year) **To** 05 / 18 / 00 (Month / Date / Year)

This individual (check one):

[X] was awarded the degree of Medicine on 05 / 27 / 00 (Month / Date / Year)

[ ] was NOT awarded a degree (please attach an explanation)

Certification: By my signature, I, Yvonne A. Harlow (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available, this form must be notarized.

SEAL VERIFIED

Signature: Yvonne A. Harlow

Title: School Registrar

Date of Signature: August 7, 2003

Phone: (412) 648-9040 **Fax:** (412) 624-0290

Email:

VERIFICATION OF MEDICAL EDUCATION

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

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

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

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

   Please Specify: _____

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

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

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

   Please specify reason: _____

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

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

   _____

   _____

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response **YES** ☐ **NO** ☒

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

   _____

   _____

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic imcompetence, disciplinary problems, or any other reason?
   Response **YES** ☐ **NO** ☒

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

   _____

   _____

University of Pittsburgh

School of Medicine
Office of Student Affairs

M-218 Scaife Hall
3550 Terrace Street
Pittsburgh, PA 15261
412-648-9040
Fax: 412-624-0290
E-mail: student_affairs@medschool.pitt.edu

LETTER OF RECOMMENDATION FOR GRADUATE MEDICAL EDUCATION
DAVID NICHOLAS HACKNEY - CLASS OF 2000

I am very pleased to write this letter on behalf of David N. Hackney, a fourth year medical student at the University of Pittsburgh School of Medicine and candidate for a first year position in graduate medical education. He comes from Pittsburgh, Pennsylvania. He completed his undergraduate studies at Carnegie Mellon University where he majored in Chemistry with a minor in English and graduated with a Bachelor of Arts degree in 1996. He had an excellent undergraduate academic record, was one of only 35 students named as an Andrew Carnegie Scholar for Academic Success and Future Potential and was inducted into Phi Beta Kappa. Along with maintaining his high standards of academic excellence, he was involved in impressive and substantial extracurricular activities. His undergraduate years were highlighted by his extensive leadership role as manager and disc jockey of WCRT campus radio station, supervising over 100 staff members. He also founded and co-hosted a weekly discussion program addressing issues of local importance and co-hosted a three hour jazz program. In addition, he elected to work as a research assistant for two and a half years, completed his EMT certification and volunteered for a local emergency medicine service (EMS) five hours per week for three years. He entered the University of Pittsburgh School of Medicine in the fall of 1996.

For the first two years, our medical school has a fully integrated, interdepartmental curriculum which includes three major basic science blocks, five organ system blocks, two patient/doctor blocks and two clinical skills blocks. Courses are graded honors/satisfactory/unsatisfactory and therefore there is no ranking system. Approximately ten to fifteen percent of students achieve honors in any one course. In the pre-clinical sciences, Dave did well academically, earning satisfactory grades in all his course work. In the small group, problem-based learning sessions, he was a well prepared and active participant. In the summer after his freshman year, he was selected for the American Medical Student Association's Health Policy Internship in Washington, D.C., where he furthered his interest in issues of health care. At the end of his second year, he passed Step 1 of the USMLE with a total score of 233, placing him in the 93rd percentile nationally.

In the third and fourth years of clinical clerkships and electives, a student may receive high and low satisfactory in addition to honors/satisfactory/unsatisfactory. In the required clerkships of the third year David performed in an above average manner. He earned honors in Pediatric Pathology and high satisfactories in Family Medicine, Internal Medicine, Pediatrics, Psychiatry and Ambulatory Sub-Specialties. Specific comments in chronological order are appended to this letter. Among the comments regarding his clinical performances are the following: "...Highly motivated, hard working and appeared to be excited about his work...open to suggestions and very enthusiastic about self-improvement...has a good fund of knowledge and a logical practical thought process...has the compassion and intellect to be a good doctor...fund of knowledge was felt to be at or above that

expected for a student at his level of training...was able to apply information to clinical scenarios...exhibited initiative and was an active member of the medical team...did an excellent job in performing a history and physical exam...clearly worked well with his peers and the house staff... reasons well...enthusiastic, energetic student..." Overall, he has been an excellent clinical clerk.

David has numerous interests and activities outside the curriculum. He played an instrumental role as co-founder of Students For Health Care Reform, a group which developed and programmed a very effective series of discussions on current topics. This material was so successful that much of it will be incorporated into our curriculum. Based on his long-term experience as an undergraduate, he initiated and co-founded a weekly radio health care policy forum, "Say Ah". Numerous experts speakers were recruited and interviewed, often by Dave, about issues such as Medicare, medico-legal topics and the ethics of managed care. In addition, he has co-authored two editorials on health care policy in the Pittsburgh Post Gazette and the Allegheny County Medical Society Bulletin. He has also made time to intermittently a two hour weekly jazz show throughout medical school. A member of the American Medical Student Association, he is active in their Literature and Medicine interest group, in which group members read and discuss a variety of topics.

David has planned a well-balanced year of senior electives, including Obstetrics Subinternship, Neonatology, Reproductive Endocrinology & Infertility, Medical Intensive Care, Plastic Surgery, Internal Medicine Subinternship, Infectious Disease, and Endocrinology and Metabolism. This is a worthwhile year which should prepare him well for his graduate medical education.

In summary, David N. Hackney is a student of exceptional maturity, keen intellect and always upbeat attitude. He has an aptitude for quick learning and a genuine excitement for clinical medicine. He came to medicine with a breadth of interests from jazz music to health policy, and a record of creative leadership. He acquired an excellent fund of basic science knowledge as evidenced by his preclinical record and his USMLE Step 1 score in the 93rd percentile nationally. He performed third year at a consistently above average level. The faculty particularly noted his initiative, self-motivation, effective technical skills, strong fund of knowledge, independent and thoughtful analysis and logical thought processes. He went on the earn Honors in his fourth year Obstetrics Acting Internship. One of Dave's greatest strengths is his warm personality. He has excellent communication skills and establishes a ready rapport with both patients and colleagues. He always treats his patients with utmost respect and professionalism. He will be an active and valuable contributor to whatever residency program he joins. We are pleased to recommend him as an excellent candidate for graduate medical education.

Sincerely yours,

Joan Harvey

Joan Harvey, M.D.
Associate Dean for Student Affairs

DAVID NICHOLAS HACKNEY - CLASS OF 2000
COMMENTS FROM COURSE EVALUATIONS IN ORDER OF COMPLETION

INTERNAL MEDICINE (07/14/98 - 09/03/98) High Satisfactory

David Hackney completed the Internal Medicine Clerkship in an above average fashion throughout the course of the rotation. His case presentations were well-organized and well thought out and included an appropriate discussion of pathophysiology behind the patients' problems. He has a good knowledge base and was able to apply it well for a first-time third-year student. His initial plans were well thought out and he made an effort to make an independent thoughtful analysis. His progress notes and follow up care were detailed and complete. He was highly motivated, hard working and appeared to be excited about his work. He got along well with both patients and colleagues and developed excellent rapport. He accepted criticism well and used it to improve. He was open to suggestions and very enthusiastic about self-improvement. His potential for future growth was judged to be excellent. Overall, he was considered to be a pleasure to have on the service."

FAMILY MEDICINE (09/08/98 - 10/02/98) High Satisfactory

"David is sincere and professional. He tried to be very thorough. David seems compassionate and pleasant...David was well liked by our staff. When we allowed David a moment to collect his thoughts, we realized he has a good fund of knowledge and a logical practical thought process. He obtained good historical information. David has the compassion and intellect to be a good doctor."

PEDIATRIC PATHOLOGY (10/05/98 - 10/31/98) Honors

"This is an unusual and somewhat difficult rotation for medical students. The major activity of the division is diagnostic histopathology of pediatric age diseases, far from the medical school mainstream (unfortunately). David, however, threw himself into the work. He assisted in the daily routine and spent long hours on study sets and in preparation for our diagnostic slide (teaching) conference. He was given the reading and review assignments for the conference that were well researched. He filled in time by participating in laboratory assignments and showed an aptitude for quick learning and effective technical skills. Overall he gets very high marks for enthusiasm, diligence, technical skills and a warm personality."

PEDIATRICS (11/02/98 - 12/23/98) High Satisfactory

"David delivered a very solid performance during the outpatient rotation of pediatrics. In a variety of settings (community pediatrics site, pediatric subspecialty clinics, acute concerns clinic) he shows an average to above-average fund of knowledge, problem-solving ability, and case presentation skills. One preceptor, who directly observed him take a history on a complicated new patient, found his skills in obtaining a history to be impressive. This is a bright and well-organized student who shows promise and will integrate his knowledge with clinical medicine over time. David received a High Pass in his outpatient rotation in pediatrics. David completed his inpatient rotation on 9N/8N at Children's Hospital of Pittsburgh during the second half of the pediatric clerkship. David did a fine job and was described as hard working, pleasant to work with and conscientious. His fund of knowledge was felt to be at or above that expected for a student at his level of training. He read on his own time and knew his patients thoroughly. He was able to apply information to clinical scenarios and was beginning to devise plans of management. His presentations were complete and accurate. David gave an excellent talk on jaundice. He exhibited initiative and was an active

PEDIATRICS (cont'd)

member of the medical team. He was able to establish a good rapport with the patients and their families. David received a grade of Pass for the inpatient rotation of the pediatric block...David received a grade of High Pass on the final examination and an overall evaluation of High Pass for the Pediatric Clerkship."

OBSTETRICS/GYNECOLOGY (01/04/99 - 02/13/99) High Satisfactory

"Mr. Hackney participated actively in all aspects of the Obstetrics and Gynecology clerkship. He took initiative in seeing patients and seemed to be motivated to learn. He was responsible in carrying out assignments. He did an excellent job in performing a history and physical exam. His histories were thorough and well prioritized. He was able to use his knowledge base effectively in formulating a differential diagnosis. His preceptor in reproductive endocrinology pointed out specifically that he had an obvious understanding of complex endocrine issues well above the level expected. He was able to perform a pelvic exam with ease. Mr. Hackney interacted well with others. He treated patients with respect and professionalism. In his PBL group, he demonstrated an extensive knowledge base. His facilitators felt that he could be more effective at applying his knowledge to clinical situations. He was well prepared for sessions and contributed appropriately to the discussions. His score on the final exam was among the highest in his group. He is given a grade of High Pass for the rotation."

PSYCHIATRY (02/15/99 - 03/27/99) High Satisfactory

"COMMENTS FROM TRAINING DIRECTOR: David received a High Pass grade in psychiatry. He completed his inpatient duties on the Schizophrenia Unit and on the Geriatrics Service. His score from both of these were independently in the High Pass Range. David demonstrated diligence and his interviewing skills and knowledge base clearly improved during the course of his clinical rotation. He wold ask interesting and suitable questions and seemed to be reading up about differential diagnoses about his patients. He was conscientious, inquisitive and sought feedback during this experience. David's performance in the Small Group Discussion which was a Substance Abuse Case Conference, was acceptable. Scores from the Outpatient clinic were in the Pass range and his preceptor commented that he had some difficulty with organizing his information. From the Emergency Room, David seemed to have demonstrated a good fund of knowledge which was consistent with his level of training. David''s score on the National Board of Medical Examiner's examination was substantially above the mean, placing him in the 90th percentile of a nationalized norm of medical students who took a shelf examination at the end of their third year clerkship. His score on the performance-based video examination was within a standard deviation below the mean for his class. Overall, a good performance on his part. No other problems or concerns were noted during his clerkship experience."

DAVID NICHOLAS HACKNEY - CLASS OF 2000
COMMENTS FROM COURSE EVALUATIONS (cont'd)

GENERAL SURGERY (03/29/99 - 05/08/99) Satisfactory

"David Hackney was assigned to the Trauma and Endocrine/General Surgery Services for his third year surgical clerkship. He impressed us as being a very intelligent,...Some felt he was apprehensive as regards actively participating in patient care. He clearly worked well with his peers and the house staff. Perhaps overly serious early in the rotation (affecting his daily presentations), this improved over the clerkship and his presentations became more fluent and better organized. Based on his exam score and conference performance, he is clearly a bright student. He has enormous potential."

AMBULATORY SUB-SPECIALTIES (05/10/99 - 06/19/99) High Satisfactory

"David Hackney performed in an excellent manner during his rotation in the Ambulatory Subspecialties Course. Comments from his preceptors included, 'Took good histories and had good physical exam skills'. Another noted, 'Very bright, knowledgeable student. Very strong performance in the office and the operating room. Reasons well, excellent fund of knowledge'. Another noted, 'Enthusiastic, energetic student...very helpful in the clinic and OR. Wrote very good notes...Able to do much of head and neck examination even without prior physical diagnosis course'."

OBSTETRICS ACTING INTERNSHIP (06/21/99 - 07/10/99) Honors

"David was described as a hard working team player, who took on extra work to achieve his goal of performing several deliveries."

ANESTHESIOLOGY (08/09/99 - 08/20/99) Satisfactory

"David is a bright, easy-going individual who is diligent in his studies. He exhibits excellent technical skills, manual dexterity, good interpersonal relations. He will do well at serving his patients and gaining their confidence and respect."

REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY (08/24/99 - 09/17/99) Honors

"David was an asset to the practice during his 4 weeks. He demonstrated excellent physical diagnosis skills and rapidly began to contribute his suggestions (appropriately) to patient management. He assisted in several operative cases and his surgical skills were at the expected level. He gave a superb presentation on the current aspects of insulin resistance in patients with polycystic ovarian disease, one of the best discussions of this complicated topic the faculty had ever heard."

PEDIATRIC NEONATOLOGY (07/12/99 - 08/07/99) High Satisfactory

"David did an excellent job presenting histories/physicals at morning rounds. Concise, to the point presentations and progress notes. He was willing to learn and help other team members. He is very easy to get along with. He learned much as the rotation progressed and he will be an excellent physician in the future. David's histories and physicals were appropriate and of sufficient detail. He prerounded on all patients and was well prepared for daily rounds. He worked hard at didactic presentations; good research on a topic he was assigned to read. He is a congenial person to work with."

DAVID NICHOLAS HACKNEY - CLASS OF 2000
COMMENTS FROM COURSE EVALUATIONS (cont'd)

NEUROLOGY (10/04/99 - 10/23/99) High Satisfactory

"Mr. Hackney did an exceptional job with his history and neurological exam and interacted well with staff while working with Associates in Neurology of Pittsburgh."

MICU (11/01/99 - 11/24/99) High Satisfactory

PLASTIC SURGERY (11/29/99 - 12/23/99) High Satisfactory

"David Hackney's performance was described as being solid. He was likable and capable. He was comfortable in clinical situations and was quite dependable. He worked well with his hands."

DIAGNOSTIC RADIOLOGY (01/31/00 - 02/18/00) Honors

"David Hackney was a highly motivated student who performed in an exemplary manner during the three week course in Diagnostic Radiology and Imaging. A combination of extensive general medical and surgical knowledge, active and enthusiastic interest in radiology, and the ability to learn quickly resulted in a performance well above his colleagues. An Honors grade was merited by his excellent performance on the written final examination, student case presentation, and active class performance."

MEDICINE ACTING INTERNSHIP (02/28/00 - 03/25/00) High Satisfactory

"Good fund of knowledge. Worked hard. Good patient rapport. Excellent potential."

INFECTIOUS DISEASE/OBSTETRICS-GYNECOLOGY (03/27/00 - 04/22/00) Satisfactory

OB/GYN PATHOLOGY (04/24/00 - 05/18/00) Honors

"David Hackney is an excellent medical student."

GRADUATE/PROFESSIONAL ACADEMIC TRANSCRIPT

UNIVERSITY OF PITTSBURGH

at Pittsburgh, PA 15260

DATE ISSUED: July 30, 2003 PAGE 01 OF 01

David N. Hackney

STUDENT ID NUMBER: Redacted

UNIVERSITY OF PITTSBURGH DEGREE(S)/CERTIFICATE(S) AWARDED

DEGREE	Doctor of Medicine; May 2000
MAJOR	Professional Program Medicine
ACAD CNTR	School of Medicine
CAMPUS	Pittsburgh

UNIVERSITY OF PITTSBURGH CREDITS

COURSE TITLE	COURSE		CREDIT	GRADE	SPECIAL NOTATION
Academic Year 1996-1997					
BASIC SCIENCE BLOCK - SECTION 1	MED	5111	0.0	S	
BASIC SCIENCE BLOCK - SECTION 2	MED	5116	0.0	S	
BASIC SCIENCE BLOCK - SECTION 3	MED	5117	0.0	S	
PATIENT/DOCTOR RELATIONSHIP	MED	5122	0.0	S	
MEDICINE, ETHICS AND SOCIETY 1	MED	5123	0.0	S	
NORMAL PHYSICAL DIAGNOSIS	MED	5132	0.0	S	
HOST DEFENSE AND MUSCULOSKELETAL	MED	5146	0.0	S	
AMBULATORY CARE - PART 1	MED	5150	0.0	S	
Academic Year 1997-1998					
ORGAN SYMS: NEUROSCIENCES	MED	5211	0.0	S	
BODY FLUID HOMEOSTASIS	MED	5216	0.0	S	
DIGESTION/DEVELOPMENT/SKIN	MED	5221	0.0	S	
CASE STUDIES	MED	5226	0.0	S	
CLINICAL SKILLS	MED	5232	0.0	S	
MEDICINE, ETHICS, AND SOCIETY 2	MED	5236	0.0	S	
AMBULATORY CARE - PART 2	MED	5250	0.0	S	
Academic Year 1998-1999					
FAMILY MEDICINE CLERKSHIP (4 WK)	FMCE	5315	0.0	S	
MEDICINE CLERKSHIP (8 WEEKS)	MED	5321	0.0	S	
AMBULATORY SUBSPECIALTIES	MED	5325	0.0	S	
PEDIATRIC PATHOLOGY	MSPTH	5450	0.0	H	
OB AND GYN CLERKSHIP (6 WEEKS)	OBGYN	5340	0.0	S	

CONTINUED ON NEXT COLUMN

UNIVERSITY OF PITTSBURGH CREDITS

COURSE TITLE	COURSE		CREDIT	GRADE	SPECIAL NOTATION
PEDIATRIC CLERKSHIP (8 WK)	PEDS	5350	0.0	S	
PSYCHIATRY CLERKSHIP (6 WK)	PSYC	5360	0.0	S	
GENERAL SURG CLERKSHIP (6 WEEK)	SURG	5370	0.0	S	
Academic Year 1999-2000					
MEDICINE ACTING INTERNSHIP	MED	5401	0.0	S	
MEDICAL INTENSIVE CARE UNIT	MED	5702	0.0	S	
JR CLERKSHIP IN ANESTH (2 WK)	MSANE	5310	0.0	S	
SURGICAL AND PERINATAL PATHOLOGY	MSPTH	5441	0.0	H	
NEUROLOGY CLERKSHIP (3 WEEKS)	NEURO	5320	0.0	S	
OBSTETRICAL SUBINTERNSHIP	OBGYN	5420	0.0	H	
REPRODUCTIVE ENDOCRINOLOGY	OBGYN	5450	0.0	H	
INFECTIOUS DISEASE-OB/GYN (ILS)	OBGYN	5725	0.0	S	
NEONATOLOGY	PEDS	5460	0.0	S	
IMAGING CLERKSHIP (3 WEEKS)	RAD	5330	0.0	H	
PLASTIC RECONSTRUCTIVE SURGERY	SURG	5450	0.0	S	

DEGREES AWARDED FROM OTHER INSTITUTIONS

Bachelor of Art 1996
Carnegie Mellon University

END OF DOCUMENT. NO ENTRIES BELOW THIS LINE

RAISED SEAL NOT REQUIRED
This official University transcript is printed on SCRIP-SAFE secured paper and does not require a raised seal.

Samuel D. Conte
University Registrar

FEDERATION CREDENTIALS
VERIFICATION SERVICE
PO BOX 619850
DALLAS TX 75261-9850

SEAL VERIFIED

A BLACK AND WHITE TRANSCRIPT IS NOT AN ORIGINAL TRANSCRIPT GUIDE ON BACK

GRADING POLICY

The following are levels of attainment and quality points associated with each grade:

		Level of Attainment		
		Undergraduate Courses	Graduate Courses	First Professional Courses
A+	4.00			
A	4.00	Superior	Superior	Exceptional
A-	3.75			
B+	3.25			
B	3.00	Meritorious	Adequate	
B-	2.75			
C+	2.25			
C	2.00	Adequate	Minimal	Adequate
C-	1.75			
D+	1.25			
D	1.00	Minimal		
D-	0.75			
F	0.00	Failure	Failure	Failure

The following grades carry no quality points:

G **Unfinished Course Work**
Course work unfinished because of extenuating personal circumstances

H **Honors**
Exceptional completion of course requirements

I **Incomplete**
Course work incomplete due to the nature of the course, clinical work or incomplete research work in individual guidance courses or seminars

N **Audit**
Non-credit

R **Resignation**
Student resigned from the University for the term

S **Satisfactory**
Course requirements satisfactorily completed

U **Unsatisfactory**
Course requirements not satisfactorily completed

W **Withdrawal**
Student withdrew from course

Z **Invalid grade**
Grade issued is invalid

** **No Grade**
Grade not issued

Discontinued Grades

K **Competent Attainment**

P **Pass**
Satisfactory completion of an independent study, directed study, teaching of courses, individual research, and thesis or dissertation research

Q **Qualified**

WF **Withdrawal/Failing**

Plus and Minus Grades

Plus and minus grades were added to the University's grading system in the Winter Term 1975-76.

SPECIAL NOTATION

1. Indicates that a course was repeated. The credits and quality points earned in this course are not used in the calculation of the QPA.
2. Indicates that the course was offered through the University Honors College.
3. Indicates that course was taken at one or more of the following colleges in conjunction with the University of Pittsburgh's cross-registration program:

CAR	Carlow College
CMU	Carnegie-Mellon University
CHA	Chatham College
CCA	Community College of Allegheny County
DUQ	Duquesne University
LAR	LaRoche College
PTS	Pittsburgh Theological Seminary
PPC	Point Park College
RMU	Robert Morris University (formerly RMC Robert Morris College)
SHC	Seton Hill College
WCC	Westmoreland County Community College

COURSE NUMBERING SYSTEM

Effective Fall Term 1990

0001-0999 or 7000-7999	Lower Level Undergraduate (7000-7999 numbering system not used after term 97-3)
1000-1999 or 8000-8999	Upper Level Undergraduate (8000-8999 numbering system not used after term 97-3)
2000-2999	Master Level Graduate
3000-3999	Doctoral Level Graduate
4000-4999	Noncredit
5000-5999	First Professional Programs (Medicine, Dental Medicine and Law)
6000-6999	Career Development Undergraduate
9000-9999	Career Development Graduate

PREVIOUS COURSE NUMBERING SYSTEM

001-099	Lower Level Undergraduate
100-199	Upper Level Undergraduate
200-299	Master Level Graduate
300-399	Doctoral Level Graduate
500-599	First Professional Programs Medicine and Dental Medicine
700-799	Lower Level (General Studies) Undergraduate
800-899	Upper Level (General Studies) Undergraduate
900-999	Other (Includes Occupation/Vocational and Special Workshops)

PREVIOUS COURSE NUMBERING SYSTEM (SCHOOL OF LAW)

010-099	First Year Sectioned Courses
100-399	Upper Level Electives
400-499	Third Year Limited Enrollment Courses
500-699	Upper Division Seminars
900-999	Activities for Credit

QPA POLICY

The University of Pittsburgh Cumulative Quality Point Average (QPA) is that QPA associated with all the University of Pittsburgh courses related to the student's degree goal(s). The cumulative QPA for those students not seeking a degree is based upon all University of Pittsburgh credits completed in accordance with the University Grading Policy. The QPA is only printed on Undergraduate Academic Transcripts. The absence of a QPA on an Undergraduate Academic Transcript indicates that the calculation is pending evaluation by the student's current academic center.

THREE-TERM CALENDAR

The University of Pittsburgh utilizes a three-term academic calendar which is equivalent to the semester hour system. The first professional programs operate on the semester calendar.

ACCREDITATION

The University of Pittsburgh is accredited by the Middle States Association of Colleges and Schools, Commission on Higher Education. Individual school or program accreditation may be verified by contacting the Dean's Office of the academic center identified on the student's record.

SEAL VERIFIED

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974

In compliance with the Family Educational Rights and Privacy Act of 1974, as amended, this document has been released on the condition that the recipient will not permit any other party or agency to have access to this record without the written consent of the student.

DEGREES AWARDED FROM OTHER INSTITUTIONS

Any information displayed reflecting degrees awarded by other institutions should be verified with the awarding institution for accuracy

TO TEST FOR AUTHENTICITY. The face of this transcript is printed on blue SCRIP-SAFE™ paper with the name of the institution appearing in blue type over the face of the entire document.

UNIVERSITY OF PITTSBURGH• UNIVERSITY OF PITTSBURGH• UNIVERSITY OF PITTSBURGH • UNIVERSITY OF PITTSBURGH • UNIVERSITY OF PITTSBURGH • UNIVERSITY OF PITTSBURGH• UNIVERSITY OF PITTSBURGH• UNIVERSITY OF

ADDITIONAL TESTS. When photocopied, a latent security statement containing the institutional name and the words COPY COPY COPY appear over the face of the entire document. When this paper is touched by fresh liquid bleach, an authentic document will stain. A black and white or color copy of this document is not an original and should not be accepted as an official institutional document. This document cannot be released to a third party without the written consent of the student. This is in accordance with the Family Educational Rights and Privacy Act of 1974. ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE! If you have any questions about this document, please contact the appropriate campus.

Bradford Campus	(814) 362-7600
Greensburg Campus	(724) 836-9900
Johnstown Campus	(814) 269-7055
Pittsburgh Campus	(412) 624-7635
Titusville Campus	(814) 827-4482

02182602

SCRIP-SAFE™ Security Products, Inc. Cincinnati, OH • U.S. Patent 5,171,04

SEAL VERIFIED

The University of Pittsburgh

SCHOOL OF MEDICINE

UPON RECOMMENDATION OF THE FACULTY,
AND BY AUTHORITY OF THE BOARD OF TRUSTEES, CONFERS UPON

DAVID NICHOLAS HACKNEY

THE DEGREE OF

DOCTOR OF MEDICINE

WITH ALL THE RIGHTS, PRIVILEGES AND RESPONSIBILITIES PERTAINING THERETO.
IN WITNESS THEREOF, THE SEAL OF THE UNIVERSITY AND THE SIGNATURES
OF THE AUTHORIZED OFFICERS ARE AFFIXED AT PITTSBURGH, PENNSYLVANIA.
MAY 27, 2000

CHAIRMAN, BOARD OF TRUSTEES

PROVOST

CHANCELLOR

DEAN, SCHOOL OF MEDICINE

This is to certify that this is a true and accurate copy of the diploma issued to David Nicholas Hackney by the University of Pittsburgh.

Sincerely,

Janet Kudrav, Supervisor
Transcripts and Certifications

SEAL
VERIFIED

Section IV

Postgraduate Training

F[illegible]ation Credentials Verification Service (FCV[illegible]

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **Ohio State University Hospital**

Address: Department of Obstetrics and Gynecology
Columbus, OH 43210-1228

Attention: Program Director

Affiliated University: _____

RECEIVED AUG 03 2003 BY

Verification For:

Name: **Hackney, David Nicholas**
SSN: Redacted
DOB: **11/27/1973**

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

Program Participation:

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

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

Report Internships, Residencies and Fellowships separately.

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

PGY: 1 ___ Internship ✓ Residency ___ Fellowship ___ Research
Department/Specialty: OB/Gyn
From: 7/1/2000 To: 6/30/2001
Successfully Completed?: ✓ Yes ___ No ___ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: 2-3 ___ Internship ✓ Residency ___ Fellowship ___ Research
Department/Specialty: OB/Gyn
From: 7/1/2001 To: 6/30/2003
Successfully Completed?: ✓ Yes ___ No ___ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

PGY: 4 ___ Internship ✓ Residency ___ Fellowship ___ Research
Department/Specialty: OB/Gyn
From: 7/1/2003 To: 6/30/2004
Successfully Completed?: ___ Yes ___ No ✓ In Progress
Accredited by: ✓ ACGME __ AOA __ LCGME __ RSC __ CFPC __ RCPSC __ APPAP __ None of these

Unusual Circumstances:

Circle the correct response. Omitted responses require written explanation.

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

Did this individual ever take a leave of absence or break from his/her training? Yes (No)
Was this individual ever placed on probation? Yes (No)
Was this individual ever disciplined or placed under investigation? Yes (No)
Were any negative reports ever filed by instructors? Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? Yes (No)

Please explain any "Yes" response from above:

SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If a seal is available, it must have this form notarized.

NOTARIAL SEAL STATE OF OHIO

TRACY L. JANOSIK Notary Public, State of Ohio My Commission Expires 12-11-06

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: Philip Samuels, MD Signature: _____
Title: Residency Program Dir. Date of Signature: 7-29-03
Phone: 614-293-3773 Fax: 614-293-5877 E-Mail: samuels.8@osu.edu

Subscribed and sworn before me this 29th day of July, 2003 @ Cols, OH

LSJ Tracy L. Janosik

Rev. 07/02/02 Packet ID: 339316 Requestor: 1880283 [10901]

Section V

Examination History/Score Transcripts

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

USMLE United States Medical Licensing Examination™

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 07/29/2003

Federation Credentials Verification Service
ATTN: Ohio

Packet ID: 33816

Examinee: Hackney, David Nicholas
USMLE ID#: 5-036-897-6
DOB: 11 / 27 / 1973
Alt Name(s):

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	6/9/1998	PASS	233	(179)	92	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	8/23/1999	PASS	243	(170)	92	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
OHIO	12/10/2002	PASS	227	(182)	92	(75)	

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

LSM

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

October 3, 2003

David N. Hackney MD
298 E. Whittier St.
Columbus, OH 43206

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **83363** was issued on **October 3, 2003** and will expire on **October 1, 2004**. A wallet card and wall certificate will be mailed to you in approximately 3 - 4 weeks.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://www.state.oh.us/med/. The website is updated approximately 7-10 business days after the date of licensure; therefore, you must maintain this letter in the interim for purposes of verifying your Ohio license for hospitals, insurance companies, etc.

The Ohio Medical Board operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. Enclosed is a chart and information outlining the staggered medical license renewal system and continuing medical education (CME) hours required. Renewal applications are mailed approximately six months prior to the date of expiration. CME information may also be obtained from the Board's website.

SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE.

This notice authorizes you to make application for a U.S. Drug Enforcement Administration certificate of registration (controlled substance permit). To make such application, contact:

Drug Enforcement Administration (DEA)
431 Howard St.
Detroit, Michigan 48226
(800) 230-6844
www.deadiversion.usdoj.gov/drugreg/index.html

Any questions regarding your DEA registration must be directed to the DEA office above.

Sincerely,

Penny E. Grubb
Chief, Licensure

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION IN COMPLIANCE WITH O.R.C. 4731.281 AND O.A.C. 4731-10, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X David Hackney 6/27/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 083363	305.00	7/1/2004	10/1/2004

Dr. DAVID NICHOLAS HACKNEY
298 E WHITTIER ST
COLUMBUS OH 43206

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG

☒ **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.

298 E Whittier St
STREET
STREET
Columbus OH 43206
CITY STATE ZIP CODE
Franklin
COUNTY

SELECT ONE ADDRESS FOR MAILINGS FROM THE BOARD.
☒ RESIDENCE ☐ PRINICIPAL PRACTICE ADDRESS

0003633391 30500 35ZZ 083363

AT ANY TIME SINCE SIGNING YOUR LA
APPLICATION FOR LICENSURE / RENEW
IN OHIO :

YES NO

1.) Have you been fou guilty of, or pled guilty or contest to, or receiv treatment or intervention lieu of conviction of, a felo or misdemeanor?

YES NO

2.) Have you been addicted or dependent upon alcohol any chemical substance; been treated for, or be diagnosed as suffering fro drug or alcohol dependen or abuse? **You may answ "NO" to this question** if y have successfully complet treatment at, or are currentl enrolled in, a program approv by this Board and have adhered to all statutory requiremer during and subsequent to treatment. You must answer "YE if you have ever relapsed. Any questions concerning progra approval or concerning this question can be directed to t board offices.

YES NO

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

YES NO

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

YES NO

5.) Have you surrendered, or consented limitation of, or to suspension, reprimand probation concerning, a license to practice a healthcare profession or state or feder privileges to prescribe controlled substances any jurisdiction? You may answer "NO" to th question if the only such surrender or conse was given to this board.

YES NO

6.) Have you had any clinical privileges or oth similar institutional authority suspended, restricte or revoked for reasons **other than failure maintain records on a timely basis or to atte staff meetings?**

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

Check this Box if you have NO principal Practice address.

Street

Street

City State Zip Code

County

REQUIRED: [redacted] Reda cted

SOCIAL SECURITY NUMBER

Date Posted:

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

11100 Euclid Avenue
MAC 5034
Cleveland, OH 44106
Cuyahoga County
United States of America
216-844-3787

License Information

License Number 35.083363
License Name David Hackney

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . MATERNAL & FETAL MEDICINE

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?

. . . . . YES

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.**

. . . . . Austinson, Katherine CNM; Coleman, Amy CNM; Cunanan, Celina CNM; Doolos, Ashley CNM; Kay, Rachel CNM; Konkoly, Ann CNM; Ruzga, Elizabeth CNM; Stroud, Leslie CNM; Winkfield, Mistie CNM.

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 30-34

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

. 10-14

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.)

. 10-14

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

. 10-14

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

. 0

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).

. 15-19

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

. 15-19

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:

. 44106

2. Enter the first county:

. . . . . Cuyahoga

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

. 5-10

3. Multi-specialty Group

. . . . . N/A

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

. . . . . YES

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.

. . . . . Ob & Gyn-Maternal and Fetal Medicine

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

. 1376516211

DEA number

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

. . . . . BH 8607016

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: 4/24/2016 1:55:13 PM

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

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

Address Information

CREDENTIAL MAIL ADDRESS

2918 Huntington
Shaker Heights, OH 44120
Cuyahoga County
David.Hackney@UHhospitals.org

License Information

License Number 35.083363
License Name David Hackney

Fees

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

Medical Board Correspondence Email

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

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS

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

. . . . . MATERNAL & FETAL MEDICINE

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?

. . . . . YES

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.**

. . . . . The following are the members of the midwife division at University Hospitals Case Medical Center: Leslie, Emily; Coleman, Amy L; Cooper, Andrea; Doolos, Ashley; Konkoly, Ann; Cunanan, Celina; Austinson, Katherine; MacGregor, Lauren; Stroud, Leslie; Winkfield Hughes, Mistie; Kay, Rachel

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 35-39

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

. 10-14

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.)

. 20-24

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

. 5-9

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

. 0

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).

. 15-19

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

. 15-19

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:

. 44120

2. Enter the first county:

. . . . . Cuyahoga

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

. 5-10

3. Multi-specialty Group

. . . . . 10+

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

. . . . . YES

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.

. . . . . Ob & Gyn-Maternal and Fetal Medicine

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

. 1376516211

DEA number

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

. . . . . BH 8607016

OARRS Registration

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

. . . . . NO

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: 8/19/2018 5:58 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.

Title
Dr.
First Name
David
Middle Name
Nicholas
Last Name
Hackney
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
11/27/1973
Email Address
david.hackney@uhhospitals.org
Phone Number
(412) 334-3055
Other Phone Number
No Response

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?
Male
What is your ethnicity?
White
In which country were you born?
United States
In which state were you born (if United States)?
California
In which city were you born?

OAKLAND

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.

2918 Huntington
Shaker Heights
OH
44120
null

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.

2918 Huntington
Shaker Heights
OH
44120
null

Military Service

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

Have you served in the military?
No
Has your spouse served in the military?
No
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:
dnhackney@hotmail.com

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 - Obstetrics and Gynecology (ABMS)
Medical SubSpeciality - Maternal and Fetal Medicine

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 signing your last application for renewal of your certificate 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?
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 - Yes

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

Question - Primary NPI Number
Answer - 1376516211

Question - Primary DEA Number
Answer - BH8607016

Question - What is your current employment status?

Answer - Actively working in a position that requires the license I am renewing

Question - Do you currently possess an active license other than that for which you are renewing?
Answer - Yes

Question - Please provide the following information for each license you currently possess: License Type, License Number, Status, Region, County of Issue, Date of Initial Issuance, Expiration Date.
Answer - MD 60945

Question - On average, how many hours per week do you work under the license for which you are currently applying or renewing?
Answer - 60

Question - How many locations are you currently working in that require the license you are renewing?
Answer - 3

Question - Please provide the following information for up to 3 locations in which you use the license you are renewing, beginning with the locations you spend the most time: Facility Name, Address, City, State, Zip Code, Health Care Facility Type
Answer - University Hospitals Cleveland Medical Center, SounthWest General Hospital, LakeHealth Hospital (Tripoint)

Question - Do you have hospital privileges?
Answer - Yes

Question - Which of the following best describes your five-year employment plan?
Answer - Maintain practice hours as is

Question - Please select a language, other than English that you personally use to communicate with patients. Do not include a language that you use with the help of an interpreter or language software.
Answer - Not Applicable

Question - What is your U.S. residency status related to your employment?
Answer - U.S. Citizen

Question - Do you consider yourself Hispanic, Latino/a or of Spanish origin?
Answer - No

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 - 8/19/2018 5:58 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
David Hackney
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 HACKNEY DAVID

Date	User	Table	Field	New	Old
5/6/2014 1:01:38 PM	Bates, J	CONTACTADDRESS	COUNTYID	Cuyahoga	Franklin
5/6/2014 1:01:38 PM	Bates, J	CONTACTADDRESS	COUNTRYIDNT	United States of America	
5/6/2014 1:01:38 PM	Bates, J	CONTACTADDRESS	PHONE	216-844-3787	
5/6/2014 1:01:38 PM	Bates, J	CONTACTADDRESS	ZIPCODE	44106	43210
5/6/2014 1:01:38 PM	Bates, J	CONTACTADDRESS	ADDRESS2	MAC 5034	1375 PERRY STREET 5TH FLR RM 588
5/6/2014 1:01:38 PM	Bates, J	CONTACTADDRESS	CITY	Cleveland	COLUMBUS
5/6/2014 1:01:38 PM	Bates, J	CONTACTADDRESS	ADDRESS1	11100 Euclid Avenue	C/O OSU HOSPS-MED EDU DEPT
8/6/2012 1:14:44 PM	Vest, P	CONTACTADDRESS	ADDRESS1	2918 Huntington	184 Glen Ellyn
8/6/2012 1:14:44 PM	Vest, P	CONTACTADDRESS	CITY	Shaker Heights	Rochester
8/6/2012 1:14:44 PM	Vest, P	CONTACTADDRESS	STATECODE	OH	NY
8/6/2012 1:14:44 PM	Vest, P	CONTACTADDRESS	ZIPCODE	44120	14618
8/6/2012 1:14:44 PM	Vest, P	CONTACTADDRESS	PHONE		(412) 334-3055
8/6/2012 1:14:44 PM	Vest, P	CONTACTADDRESS	COUNTYID	Cuyahoga	Out of State
8/6/2012 1:14:18 PM	Vest, P	CONTACTADDRESS	ACTIVE	Deleted	Active
6/21/2012 8:56:31 AM	Vest, P	CONTACTADDRESS	CITY	Rochester	COLUMBUS
6/21/2012 8:56:31 AM	Vest, P	CONTACTADDRESS	STATECODE	NY	OH
6/21/2012 8:56:31 AM	Vest, P	CONTACTADDRESS	ZIPCODE	14618	43206
6/21/2012 8:56:31 AM	Vest, P	CONTACTADDRESS	PHONE	(412) 334-3055	
6/21/2012 8:56:31 AM	Vest, P	CONTACTADDRESS	COUNTYID	Out of State	Franklin
6/21/2012 8:56:30 AM	Vest, P	CONTACTADDRESS	ADDRESS1	184 Glen Ellyn	298 E WHITTIER ST
6/21/2012 8:55:51 AM	Vest, P	CONTACTADDRESS	ADDRESS1	184 Glen Ellyn	298 E WHITTIER ST
6/21/2012 8:55:51 AM	Vest, P	CONTACTADDRESS	CITY	Rochester	COLUMBUS
6/21/2012 8:55:51 AM	Vest, P	CONTACTADDRESS	STATECODE	NY	OH
6/21/2012 8:55:51 AM	Vest, P	CONTACTADDRESS	ZIPCODE	14618	43206
6/21/2012	Vest, P	CONTACTADDRESS	PHONE	(412) 334-3055	

8:55:51 AM					
6/21/2012 8:55:51 AM	Vest, P	CONTACTADDRESS	COUNTYID	Out of State	Franklin
6/21/2012 8:46:55 AM	Vest, P	CONTACT	COMMENTS	Received application for license restoration 06/01/2012.	