NO.

47-9-16
8-26-82
185-00 pd
364

STATE MEDICAL BOARD OF OHIO

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

SECTION 1: Identification Information- Answer All Questions

1. Present Legal Name: Hewitt (last) Katherine (first) Denise (middle) ______ maiden (if applicable)

2. Address: 3618 Paxton Apt. 2 (street & number)
Cincinnati (city) Ohio (state) 45208 (zip code) Hamilton (country)

Intended place of practice: Cincinnati (city) OH (state) Hamilton (county)

Telephone: Business 513-559-6000 (area code) Home: 513-871-7868 (area code)

4. Place of Birth: Springfield (city) OH (state) Clark (country) Date of Birth: 9 (mo.) - 24 (day) - 54 (year)

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

6. Physical description:
Color of Hair brown Color of Eyes blue Height 5' 6"
Build med. Marks scar (L) elbow Weight 140 lbs

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

✓ U.S. Birth Certificate

____ Certificate of Naturalization
Number ____ Date Issued ____ City/State ____

____ Declaration of Intention (issued by the U.S. District Court)
Number ____ Date Issued ____ City/State ____

____ Alien Registration Receipt Card (issued by Dept. of Immigration & Naturalization)
Number ____ Date Issued ____ City/State ____

____ Approved Petition for Immigrant Visa (issued by Dept. of Immigration & Naturalization)
Number ____ Date Issued ____ City/State ____

____ Other, specify ____

Hewitt, Katherine D.

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

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

NA
Name ____ used from: mo./yr. ____ to ____ mo./yr.

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

SECTION 2: Educational Background

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

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

name	address	From: mo/day/yr	To: mo/day/yr	degree
Ohio State Univ College of Medicine	10th Ave, Columbus, OH	7/78	6/81 (6-12-81)	M.D.

Revised April 1, 1982

You must submit a copy of your original language diploma whether you are an American or foreign graduate.

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

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

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

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

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

Number NA _______ Date _______

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

SECTION 3: Postgraduate Training

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

Date mo/yr-mo/yr	Hospital	Complete Address	Position & Department	% Clin.	% Admi
7/81 - 7/82	Bethesda Hospital	619 Oak St. Cincinnati, OH 45206	PG 2 OBGYN	100	0

Total Number of Months in Approved* Training: 13
*Approved by LCME, AOA, or in Canada.

SECTION 4: Licensure Information- Answer All Questions

1. a) Are you a diplomate of the National Board of Medical Examiners?
Yes (✓) No ( ) If so, specify year 1982
Are you a diplomate of the National Board of Examiners for Osteopathic Physicians and Surgeons?
Yes ( ) No ( ) If so, specify year _______
Are you a licentiate of the Medical Council of Canada?
Yes ( ) No ( ) If so, specify year _______

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

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

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

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

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

State	Date of Issuance	License Number	Current	
NA			YES ( )	NO ( )
			YES ( )	NO ( )
			YES ( )	NO ( )
			YES ( )	NO ( )
			YES ( )	NO ( )

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

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

4. Field of Specialization

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

Field	Board Certified		Year Certified	Country
OBGYN	YES ( )	NO (✓)		
	YES ( )	NO ( )		

SECTION 5: General Information- Answer All Questions

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

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

   STATE__________ DATE__________ CHARGE__________

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

   If so, specify:____________________
   State or country Reason Date

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

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

   If so, specify:____________________
   State or country Court Offense

   ____
   Date Disposition

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

If so, specify:____
Reason Date

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

If so, specify:____
School, Hospital or Institution

____
City/State Country

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

If so, specify____
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 – 7/82	Bethesda Hosp	619 Oak St. Cincinnati, OH 45206	PG I OB GYN	100	0

FORM 3

CERTIFICATE OF RECOMMENDATION

MUST BE COMPLETED FOR ALL APPLICANTS

This form is to be completed by a fully licensed physician in the state in which the form is notarized. The recommending physician should be sufficiently acquainted with the applicant for at least a six month period as to be able to evaluate and recommend the applicant. No relatives can serve as recommending physician. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

I, Harold E. Johnstone, M.D. (Recommending Physician), a licensed and practicing physician in the state of Ohio, affirm that Katherine D. Hewitt, M.D. has been known to me personally and professionally for 2 years and that he/she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as above average

His/her command of the English language is superlative

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

His/her relationship with patients is excellent

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

I hereby recommend Katherine D. Hewitt, M.D. (Applicant) for full licensure to practice Medicine in Ohio.

Univ. of Cinn., College of Medicine
Medical School of Graduation of Recommending Physician

Harold E. Johnstone MD
Signature of Recommending Physician

Ohio
State of Licensure of Recommending Physician

Harold E. Johnstone, M.D.
Name of Recommending Physician (Please print)

#25168
License No. of Recommending Physician

105 Bethesda Oak Professional Center
Cincinnati, Ohio 45206
Address of Recommending Physician

513-559-6341
Telephone Number (Include area code)

Subscribed and sworn to this 15th day of July, 1982.

(SEAL)

Nora M. Losh
Notary Public
[illegible] M. LOSH
[illegible] State of Ohio
Date Commission Expires [illegible] 14, 1983

UPON COMPLETION, RETURN TO:

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

FORM 3

CERTIFICATE OF RECOMMENDATION

MUST BE COMPLETED FOR ALL APPLICANTS

This form is to be completed by a fully licensed physician in the state in which the form is notarized. The recommending physician should be sufficiently acquainted with the applicant for at least a six month period as to be able to evaluate and recommend the applicant. No relatives can serve as recommending physician. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

I, Karl Ziesmann, M.D. (Recommending Physician), a licensed and practicing physician in the state of Ohio, affirm that Katherine D. Hewitt, M.D. has been known to me personally and professionally for 1 years and that he/she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as excellent

His/her command of the English language is excellent

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

His/her relationship with patients is excellent

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

I hereby recommend Katherine D. Hewitt, M.D. (Applicant) for full licensure to practice Medicine in Ohio.

Univ. of Cinn., College of Medicine
Medical School of Graduation of Recommending Physician

Karl Ziesmann MD
Signature of Recommending Physician

Ohio
State of Licensure of Recommending Physician

Karl Ziesmann, M.D.
Name of Recommending Physician (Please print)

#20566
License No. of Recommending Physician

4966 Glenway Avenue
Cincinnati, Ohio 45238
Address of Recommending Physician

513-251-6002
Telephone Number (Include area code)

Subscribed and sworn to this 20 day of July, 1982.

(SEAL)

Carol J Carter
Notary Public

March 14 1983
Date Commission Expires

UPON COMPLETION, RETURN TO:

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

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

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

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

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

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

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

SECTION 9: Release of Applicant

STATE OF OH

COUNTY OF Hamilton ss:

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

Katherine L. Hewitt
(Signature of Affiant)

Subscribed and sworn to this 14th day of July, 19 [illegible]

[signature]
(Signature of Official Administering Oath)

(SEAL)

(Date Commission Expires)

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

SECTION 10: Affidavit of Applicant

STATE OF OH

COUNTY OF Hamilton SS:

Before me, personally appeared Katherine D. Hewitt [signature]
(Affiant)

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

Katherine L. Hewitt
(Signature of Affiant)

Subscribed and sworn to this 14th day of July, 19 [illegible].

(SEAL)

[signature]
(Signature of Official Administering Oath)

(Date Commission Expires)

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

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

No. 62234

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

Entrance Examiner

Secretary

9.13.82

Date Issued

FOR BOARD USE ONLY

NAME: Hewitt, Katherine D.

CERTIFICATE NO. 48288 DATE ISSUED 11/16/82

FILED 7/1, 1982

FEE $175.00

DETERMINATION: Color Photo 11-5-82

BOARD ACTION: Bd. Approved Sept. 8(?) '82

BASIS OF LICENSURE:

Revised:

1 Katherine D. Hewitt

Signature of Applicant

2 Katherine D. Hewitt

Signature of Applicant

DATE PHOTOGRAPH TAKEN 1981

I hereby certify that the photograph on the reverse side to which this slip is pasted is a genuine likeness of

Katherine D. Hewitt

Applicant's Name (Please print)

who was recommended by me to the State Medical Board for a license to practice in Ohio.

1 [illegible]

Signature of First Endorser

Date

2 [illegible] MD

Signature of Second Endorser

7/20/82

Date

CENSUS BLANK

TO THE ENTRANCE EXAMINER, STATE MEDICAL BOARD

COLUMBUS, OHIO 43215

47-9-18
8-26-82
185.00 pd
364

My name IN FULL is Katherine (First) Denise (Middle) Hewitt (Last)

Place of birth Springfield, OH Date of birth 9 (Month) 24 (Day) 54 (Year)

Permanent or home address 3418 (Number) Paxton Apt. 2 (Street) Cincinnati (City) Ohio (State) 45208 (Zip)

Present mailing address " (Number) " (Street) " (City) " (State) " (Zip)

I have attended school as follows: (State name, location, and whether high school, normal school or college)

Univ. of Georgia, Athens, Ga. ✓ for 3 years, from 1972 (Year) to 1975 (Year)

Ohio State Univ, Columbus, OH for 3 years, from 1978 (Year) to 1981 (Year)

for ____ years, from ____ (Year) to ____ (Year)

I was graduated from Ohio State Univ. College of Medicine (College, University, etc.)

located at Columbus (Town) OH (State) (Zip) in 1981 (Year) Degree M.D.

9/13/82
60
R2B

(Signed by applicant) Katherine D. Hewitt M.D.

60334

Dated 7/13/82

(OVER)

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

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Katherine Denise Hewitt, M.D.

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

Attest WILLIAM D. HOLDEN
Chairman of the Board

SEAL

EDITHE J. LEVIT
President of the Board

Philadelphia, Pa.
07/01/82

Certificate # 257563

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from OHIO STATE U COL OF MED in JUNE ,1981 and whose birth date is 09/24/1954 This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 09/79		
Anatomy, incl. histology and embryology	515	81
Physiology	450	77
Biochemistry	455	84
Pathology	405	75
Microbiology, incl. immunology	510	81
Pharmacology and Materia Medica	455	79
Behavioral Sciences	375	73
TOTAL TEST (Minimum Passing Score 380/75)	465	79
Part II passed 04/81		
Internal medicine and the medical specialties	420	81
Surgery and the surgical specialties	420	79
Obstetrics and Gynecology	665	90
Public Health and Preventive Medicine	430	79
Pediatrics	475	81
Psychiatry	560	85
TOTAL TEST (Minimum Passing Score 290/75)	525	82
PART III passed 03/82		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	455	8[illegible].5

GENERAL AVERAGE (Parts, I, II, and III Scale Score) 80.2

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

Ann K. Heverling
Secretary for Certification

09/24/82
Date

SEAL

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

[illegible] Medical Boards
[illegible] United States

SEP 1 [illegible] 1982

PREV. CORRES. ______
ANS. ______ FILE ______
CHECK ______
BY ______

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

Dear Mrs. Fisher:

The following physician has applied for endorsement licensure in Ohio:

[illegible], Catherine Denise, M.D.

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

Sincerely,

Angela Albert

Angela Albert
Chief, Licensure

Derogatory Information:

Date SEP 21 1982

[illegible]bie
[illegible]
[illegible]

[illegible], M.D.
Executive [illegible]-Secretary

AA

STATE OF OHIO
THE STATE MEDICAL BOARD

Suite 510
65 South Front Street
Columbus, Ohio 43215

DATE September 13, 1982

Dear Doctor,

Dr. HEWITT, Katherine Denise, M.D. who is/was PG-1 OB/GYN 7/81-7/82 is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? Two years.

(2) What was/is your supervisory capacity? Chairman, Dept. of Ob/Gyn, and Attending Staff physician.

(3) At what hospital? Bethesda Hosp., 619 Oak St., Cinn., OH 45206

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

(5) In your opinion, is this doctor a person of good moral and ethical character? Yes, of the highest quality.

(6) Does this doctor work well with peers and medical staff? Extremely well.

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

(8) How is his/her command of the English language? (If applicable) Not applicable

(9) Would you recommend this doctor for licensure? Without reservation.

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

Dr. Katherine Hewitt is one of our best residents. She is the type person that goes out of her way to be helpful and takes on extra assignments beyond what is required of her. She is an excellent physician and will be an asset in the specialty of Ob/Gyn.

Please return this form to the Ohio State Medical Board at the above address,

Sincerely,

Angela Albert

Angela Albert
Chief, Licensure

Karl Ziesmann M.D.

Signature of Doctor, please type or print name legibly beneath Karl Ziesmann, M.D.,

Chairman, Department of Obstetrics & Gynecology, Bethesda Hospital
Position

DATE

Telephone No. 513-559-6249 (Include Area Code)

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

'82 ... 11 05
... THE STATE MEDICAL BOARD

9/13/82

Dear Doctor Hewitt

Your credentials and application for endorsement licensure have been reviewed. However, to complete the processing of your credentials for the Board:

_____ Send a notarized copy of your diploma, in it's original language, which conferred the degree of Doctor of Medicine.

_____ Send an original certified translation of your medical school diploma.

_____ Complete the enclosed affidavit form. This must be notarized.

_____ Send a resume of your activities (in chronological order) since you graduated from medical school. You must account for all time (working and non-working). If non-working, explain what you were doing and where. You should give exact dates, (month and year), places (with complete addresses) and activities. PLEASE USE THE ENCLOSED FORM.

_____ Part of your credentials are issued in one name, and part in another name. You must supply the appropriate legal document which authorizes the name change (NOTARIZED COPY). Any document in a foreign language must be accompanied by an official, certified translation.

_____ The license you wish to endorse is based on an endorsement. Ohio does not endorse an endorsement. You must endorse the license of the state where you sat for a written exam.

_____ Why was there a delay between the time you took your examination and the time you were licensed in ____________________?

_____ We have not received the endorsement fee of $150 by certified check, cashier's check or money order. THE $150 ENDORSEMENT FEE IS NOT REFUNDABLE OR TRANSFERABLE.

_____ Your preliminary education number has not been issued. Enclosed is a duplicate Census Blank from which this number is issued. Fill out the form and return it with a money order, certified check or cashier's check for $10. THE $10 FEE IS NOT REFUNDABLE.

_____ Your photoslip was not endorsed by the same two licensed physicians/osteopaths who signed the Certificate of Recommendation (Form 3) on your application. Duplicate forms are enclosed to be properly completed.

_____ Form _____ has not been properly notarized. All affidavits must be sworn before a Notary Public or Federal Officer who is allowed to administer oaths. They must have the Notary's seal or stamp. Duplicate forms are enclosed.

__X__ We did not receive a recent color photograph of yourself. Please submit.

_____ We have not received your Endorsement of Certification from the National Board of Medical Examiners.

_____ We have not received your Transcript of Grades from the National Board of Examiners for Osteopathic Physicians and Surgeons.

_____ We have not received a certified copy of your FLEX scores from the Federation of State Medical Boards.

_____ We have not not received Form 4, which must be certified by the State in which you are licensed by written examination.

The Ohio State University

hereby confers upon

Katherine Denise Hewitt

the degree of

Doctor of Medicine

together with all the rights, privileges and honors appertaining thereto in consideration of the satisfactory completion of the course prescribed in

The College of Medicine

In Testimony Whereof, the seal of the University and the signatures as authorized by the Board of Trustees are hereunto affixed.

Given at Columbus on the twelfth day of June, in the year of our Lord nineteen hundred eighty-one and of the University the one hundred and twelfth.

Chairman of the Board of Trustees

Harold L. Enarson
President of the University

Secretary of the Board of Trustees

BETHESDA HOSPITAL

619 Oak Street • Cincinnati, Ohio 45206 • 559-6249

DEPARTMENT OF OBSTETRICS and GYNECOLOGY

June 4, 1982

HAROLD E. JOHNSTONE, M.D.
Director

Ohio State Medical Board
65 S. Front Street
Room 510
Columbus, Ohio 43215

Gentlemen:

I would appreciate it if you would send me an application for permanent licensure in the State of Ohio.

I am entering my second year of Residency in Obstetrics and Gynecology at Bethesda Hospital.

If I can supply any additional information, please do not hesitate to contact me.

Sincerely,

Katherine D. Hewitt M.D.

Katherine D. Hewitt, M.D.
Department of Obstetrics and Gynecology

KDH:pb

Sent app
7/1/82

... hospital staff privileges? YES ( ) NO (✓)

If so, specify ______________________________
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 – 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG1 OBGYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

'82 SEP 28 PM 2 26

NAME: HEWITT, Katherine Denise

SCHOOL OF GRADUATION: Ohio State University SCHOOL LOCATION: Columbus, OH

DATE DEGREE CONFERRED: 6/12/81 DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82 GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

... hospital staff privileges? YES ( ) NO (✓)

If so, specify ______________________________
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 – 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG 1 OB GYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: HEWITT, Katherine Denise

SCHOOL OF GRADUATION: Ohio State University

SCHOOL LOCATION: Columbus, OH

'82 SEP 20 AM 11 48

DATE DEGREE CONFERRED: 6/12/81

DEGREE CONFERRED: M.D.

STATE MEDICAL BOARD

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82 GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

JERAULD B. FERRITTO, D.P.M.

... hospital staff privileges? YES ( ) NO (✓)

If so, specify ___________________________
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 – 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG1 OBGYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: HEWITT, Katherine Denise

SCHOOL OF GRADUATION: Ohio State University

SCHOOL LOCATION: Columbus, OH

DATE DEGREE CONFERRED: 6/12/81

DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82

GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

WALTER H. PAULO

... hospital staff privileges? YES ( ) NO (✓)

If so, specify ____________________
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 – 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG I OB GYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: HEWITT, Katherine Denise 17

SCHOOL OF GRADUATION: Ohio State University

SCHOOL LOCATION: Columbus, OH

DATE DEGREE CONFERRED: 6/12/81

DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82

GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

... hospital staff privileges? YES ( ) NO (✓)

If so, specify ______________________________
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 – 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG 1 OB GYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: HEWITT, Katherine Denise '82 SEP [illegible] 26

SCHOOL OF GRADUATION: Ohio State University SCHOOL LOCATION: Columbus, OH

DATE DEGREE CONFERRED: 6/12/81 DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82 GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

JOSE[illegible]

... hospital staff privileges? YES ( ) NO (✓)

If so, specify · ______________________________
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 – 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG1 OBGYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

'82 SEP 23

NAME: HEWITT, Katherine Denise

SCHOOL OF GRADUATION: Ohio State University

SCHOOL LOCATION: Columbus, OH

DATE DEGREE CONFERRED: 6/12/81

DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82

GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
√		

... hospital staff privileges? YES ( ) NO (✓)

If so, specify ______________________________
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 - 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG 1 OB GYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: HEWITT, Katherine Denise

SCHOOL OF GRADUATION: Ohio State University

SCHOOL LOCATION: Columbus, OH

DATE DEGREE CONFERRED: 6/12/81

DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82

GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

... hospital staff privileges? YES ( ) NO (✓)

If so, specify ____
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
?/81 – 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG I OB GYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

'82 SEP 23 AM 11 45

NAME: HEWITT, Katherine Denise

SCHOOL OF GRADUATION: Ohio State University

SCHOOL LOCATION: Columbus, OH

DATE DEGREE CONFERRED: 6/12/81

DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82

GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
√		

LUCY OXLEY M. D.

... hospital staff privileges? YES ( ) NO (✓)

If so, specify ____________________
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 – 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG1 OBGYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

'82 SEP 23 ... 36

NAME: HEWITT, Katherine Denise

SCHOOL OF GRADUATION: Ohio State University

SCHOOL LOCATION: Columbus, OH

DATE DEGREE CONFERRED: 6/12/81

DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82

GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
ELC		

EVELYN L. COVER, D.O.

... hospital staff privileges? YES ( ) NO (✓)

If so, specify ______________________________
Hospital or Institution

____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Hewitt, K.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM.
7/81 – 7/82	Bethesda Hosp.	619 Oak St. Cincinnati, OH 45206	PG1 OBGYN	100	0

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: HEWITT, Katherine Denise '82 SEP 23 53

SCHOOL OF GRADUATION: Ohio State University SCHOOL LOCATION: Columbus, OH

DATE DEGREE CONFERRED: 6/12/81 DEGREE CONFERRED: M.D.

INTERNSHIP:

RESIDENCY: Bethesda Hospital Cincinnati, OH 7/81-7/82

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 7/1/82 GENERAL AVERAGE: 80.2%

LETTERS OF RECOMMENDATION: Harold E. Johnstone, M.D. Cincinnati, OH

Karl Zeismann, M.D. " "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: NO

AMA INFORMATION: OK

FEDERATION INFORMATION: OK

RECOMMENDATION FORMS: OK

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
X		

M.D.

STATE OF OHIO STATE MEDICAL BOARD

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

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

Katherine D. Hewitt 11/1/84
(SIGNATURE OF APPLICANT) (DATE)

INSTRUCTIONS

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

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

IDENTIFICATION NUMBER
35-04-8288

1 KATHERINE DENISE HEWITT
3618 PAXTON, APT 2
CINCINNATI OH 45208

0 1 0 0 3 1

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME 04 FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD → 64
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS → 39
(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00
DATE DUE 11/15/84

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

OP-0345-F

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

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

Hewitt Katherine D.
LAST NAME FIRST NAME INITIAL

619 Oak St. Bethesda Hosp. OBGYN Dept.
STREET ADDRESS

Cincinnati Ohio 45208
CITY STATE ZIP CODE

Hamilton

SOCIAL SECURITY NUMBER [redacted]

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

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

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

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

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

-0345-B

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

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

Katherine D. Hewitt M.D.
(SIGNATURE OF APPLICANT) (DATE) 1/6/87

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

TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

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

IDENTIFICATION NUMBER
35-04-8288

1 KATHERINE DENISE HEWITT
3618 PAXTON, APT 2
CINCINNATI OH 45208

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

Hewitt	Katherine	D
LAST NAME	FIRST NAME	INITIAL

2396 Bretton
STREET ADDRESS

Cincinnati	OH	45244
CITY	STATE	ZIP CODE

Hamilton
COUNTY

MD & DO SPECIALTY CODES
ENTER ALL SPECIALTY CODES → 39
(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE	DATE DUE
$100.00	11/15/86

EDM-14946

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

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

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

Hewitt	Katherine	D.
LAST NAME	FIRST NAME	INITIAL

2396 Bretton
STREET ADDRESS

Cincinnati	OH	45244
CITY	STATE	ZIP CODE

Hamilton

SOCIAL SECURITY NUMBER [redacted]

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

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

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

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

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

STATE MEDICAL BOARD OF OHIO

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

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

X

(SIGNATURE OF APPLICANT) (DATE)

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

IDENTIFICATION NUMBER
35-04-8288

1 KATHERINE DENISE HEWITT
3618 PAXTON, APT 2
CINCINNATI OH 45208

#1051
1-13-87
W.cd

MD & DO SPECIALTY CODES
ENTER ALL → SPECIALTY CODES [ ] [ ] [39]
(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00 DATE DUE 11/15/86

EDM-14946

INSTRUCTIONS

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

TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

Hewitt KAtherine D
LAST NAME FIRST NAME INITIAL

2396 Bretton
STREET ADDRESS

Cincinnati OH 45244
CITY STATE ZIP CODE

HAmilton
COUNTY

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

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

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

Hewitt Katherine D.
LAST NAME FIRST NAME INITIAL

2396 Bretton
STREET ADDRESS

Cincinnati OH 45244
CITY STATE ZIP CODE

Hamilton

SOCIAL SECURITY NUMBER [redacted]

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

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

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

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

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

EDM-14946-B

STATE MEDICAL BOARD OF OHIO

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

Katherine Denise Hewitt

(SIGNAURE OF APPLICANT) (DATE)

INSTRUCTIONS

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

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

IDENTIFICATION NUMBER 35-04-8288

QT-00223-OF

1 KATHERINE DENISE HEWITT
2396 BRETTON
CINCINNATI OH 45244

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD 39
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00 DATE DUE 11/01/88

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME	FIRST NAME	INITIAL
Hewitt	Katherine	D.

STREET ADDRESS: 8074 Beechmont Ave./Bldg C

CITY	STATE	ZIP CODE
Cincinnati	Ohio	45255

COUNTY: Hamilton

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

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

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

LAST NAME	FIRST NAME	INITIAL
Hewitt	Katherine	D.

STREET ADDRESS: 8074 Beechmont Ave. /Bldg. C.

CITY	STATE	ZIP CODE
Cincinnati	Ohio	45255

Hamilton

SOCIAL SECURITY NUMBER [redacted]

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

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

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

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

YES	NO	
☐	☑	1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer no to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all statuatory requirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.
☐	☑	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☑	3.) Surrendered or consented to limitation upon a license to practice medicine or state or federal privileges to prescribe controlled substances?
☐	☑	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-OB

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

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

X Katherine D. Hewitt M.D. 9/28/90
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-04-8288	$160.00	11/01/90

KATHERINE DENISE HEWITT, M.D.
8074 BEECHMONT AVE
BLDG C
CINCINNATI OH 45255

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

[✓] SPECIALTY CODE(S) CORRECT AS LISTED

PROCESSED 30900 9224

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

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

⑆969696962⑆ 0935048288⑈ ⑈0000016000⑈

...L PRACTICE ADDRESS - IF DIFFERENT ...E ADDRESS SHOWN ON FRONT:

State Zip Code

989 00087 101190 01428 TAX BATCH P.DATE SEQ# MO# 160.00 101190 AMOUNT BATCHDATE 9350468288 ACCOUNT #

30900 9224

...U BEEN FOUND GUILTY OF, OR ...UILTY OR NO CONTEST TO :

A.) A felony

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

...TIME SINCE SIGNING YOUR ...PLICATION FOR RENEWAL OF ...ERTIFICATE HAVE YOU :

1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO 2.) Had any disciplinary action taken or initiated against you by any state licensing board?

YES NO 3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO 4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

STATE MEDICAL BOARD OF OHIO

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

November 26, 1990

STATE MEDICAL BOARD
90 NOV 30 AM 10:53

Katherine D. Hewitt, M.D.
8074 Beechmont Ave., Bldg. C
Cincinnati, OH 45255

Dear Doctor:

We have received your application for renewal of your Ohio license.

Please be advised that in reviewing your renewal application card we noted that you failed to answer all of the following questions. In order to continue processing your renewal we must have your response to each of these questions. Check the correct response to each question, sign and date this form as provided below, and return it directly to the Board offices at, 77 South High Street, 17th Floor, Columbus, Ohio, 43266-0315.

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

YES NO

[ ] [✓] A) A felony

[ ] [✓] B) A federal or state law regulating the possession, distribution or use of any drug?

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

YES NO

[ ] [✓] 1. Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO

[ ] [✓] 2. Had any disciplinary action taken or initiated against you by any state licensing board?

YES NO

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

YES NO

[ ] [✓] 4. Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?

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

K. Hewitt M.D.
Signature of Applicant

11/27/90
Date

****

If your response is not received in this office by December 31, 1990, your Ohio license will lapse by action of law.

Should you have any questions concerning the above, please do not hesitate to contact me at the above address.

Sincerely,

Debra L. Jones

Debra L. Jones, Chief
CME, Records and Renewal

DLJ:men

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

x Katherine Denise Hewitt M.D. 6/3/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-8288	$160.00	07/01/92

KATHERINE DENISE HEWITT, M.D.
8074 BEECHMONT AVE
BLDG C
CINCINNATI OH 45255

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

PROCESSED 39 SPECIALTY CODE(S) CORRECT AS LISTED

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

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

⑆969696962⑆ 0935048288⑈ ⑈0000016000⑈

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

Street
Street
City State Zip Code
County

TAX BATCH C DATE SEQ# 883 00076 061592 01083
MD# AMOUNT BATCHDATE 160.00 061792
ACCOUNT # 9350 48288

PROCESSED 06/16/92 55946?

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

YES NO ✓ A.) A felony or misdemeanor.

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

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

YES NO ✓ 1.) Been addicted to or dependent upon alcohol or any chemical substance, or been treated for, or been diagnosed as suffering from drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C. and related provisions; or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO ✓ 2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO ✓ 3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO ✓ 4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Katherine D. Hewitt 7/21/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-8288	$250.00	05/01/94

~~KA~~THERINE DENISE HEWITT,M.D.
8074 BEECHMONT AVE
BLDG C
CINCINNATI OH 45255

2-7 2-7
9-3-39 2-9-30
9-6-94 8-22-94
25.00 pc 250.00 pc
1346 ⑆96969696⑆ 1302

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET: 71 EAST HOLLISTER
STREET:
CITY: CINCINNATI STATE: OH ZIP CODE: 45219
COUNTY: HAMILTON

0935048288⑈ ⑈0000025000⑈

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

Street: 71 EAST HOLLISTER
Street:
City: CINCINNATI State: OH Zip Code: 45219
County: HAMILTON

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

YES	NO	
☐	☑	1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.
☐	☑	2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?
☐	☑	3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.
☐	☑	4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?
☐	☑	5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?
☐	☑	6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?
☐	☑	7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?
☐	☑	8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Katherine D. Hewitt 3/19/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-8288	$250.00	05/01/96

KATHERINE DENISE HEWITT, M.D.
71 EAST HOLLISTER
CINCINNATI OH 45219

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

[✓] SPECIALTY CODE(S) CORRECT AS LISTED

PROCESSED 04/17/96 555862

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

REPORT ANY CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

⑆96969696 2⑆ 0935048288⑈ ⑈0000025000⑈

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

Street

Street

City State Zip Code

County

883 00145 041696 00594
TAX BATCH # DATE SEQ# MC#

250 00 041696
AMOUNT BATCHDATE

935048288
ACCOUNT #

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

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

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

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

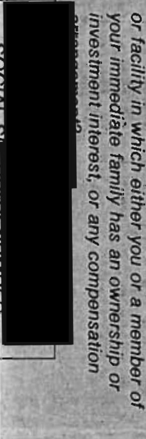
YES [ ] NO [✓] 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

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

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

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

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



DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Katherine D. Hewitt 3/3/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-8288-H	$275.00	05/01/98

KATHERINE DENISE HEWITT,M.D.
71 EAST HOLLISTER
CINCINNATI OH 45219

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

⑆96969696 2⑆ 0935048288⑈ ⑈0000027500⑈

FROM THE ADDRESS SHOWN ON FRONT:
Street
Street
City HAMILTON State Zip Code
County

033 00071 031998 00151 275.00 031998 935048288
TX-BATCH P-DATE SEQ# MC# AMOUNT BATCHDATE ACCOUNT #

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

YES ☐ NO ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

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

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

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

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

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

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

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

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2000 - 2002 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X K. Hewitt 4/18/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-04-8288-H	$305.00	07/01/02	10/01/02

KATHERINE DENISE HEWITT,M.D.
2396 BRETTON DR
CINCINNATI OH 45244

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
~~OBG OBSTETRICS & GYNECOLOGY~~
GYN Gynecology

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.
2396 Bretton Drive
STREET

STREET
Cincinnati OH 45244
CITY STATE ZIP CODE
Hamilton
COUNTY

0935048288 30500

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

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

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

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

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

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

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

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

Street
Cincinnati OH 45219
City State Zip Code
Hamilton
County

REQUIRED:
[redacted]
SOCIAL SECURITY NUMBER

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 Katherine D. Hewitt 4/27/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 048288	305.00	7/1/2004	10/1/2004

Dr. KATHERINE DENISE HEWITT
2396 BRETTON DR
CINCINNATI OH 45244

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GYN

[✓] **SPECIALTY CODE(S) CORRECT AS LISTED**

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

STREET: 2396 Brettin Dr
STREET:
CITY: Cincinnati STATE: OH ZIP CODE: 45244
COUNTY: Hamilton

SELECT ONE ADDRESS FOR MAILINGS FROM THE BOARD.
[ ] RESIDENCE [✓] PRINICIPAL PRACTICE ADDRESS

0003668313 30500 35ZZ 048288

0003668313
0309 144

AT ANY TIME SINCE SIGNING YOUR L[...] APPLICATION FOR LICENSURE / RENEW[...] IN OHIO :

YES [ ] NO [X] 1.) Have you been fou[...] guilty of, or pled guilty or [...] contest to, or recei[...] treatment or intervention [...] lieu of conviction of, a fel[...] or misdemeanor?

YES [ ] NO [X] 2.) Have you been addicted or dependent upon alcohol [...] any chemical substance; [...] been treated for, or be[...] diagnosed as suffering fr[...] drug or alcohol depender[...] or abuse? <u>You may ansv[...] "NO" to this question</u> if y[...] have successfully complet[...] treatment at, or are current[...] enrolled in, a program approv[...] by this Board and have adhered to all statutory requireme[...] during and subsequent to treatment. You must answer "YE[...] if you have ever relapsed. Any questions concerning progr[...] approval or concerning this question can be directed to [...] board offices.

YES [ ] NO [X] 3.) Have any malpractice awards or settleme[...] been paid by you or on your behalf for ac[...] occurring in any state other than Ohio?

YES [ ] NO [X] 4.) Has any board, bureau, department, agency, [...] other body, including those in Ohio, <u>other th[...] this board,</u> filed any charges, allegations [...] complaints against you?

YES [ ] NO [X] 5.) Have you surrendered, or consented [...] limitation of, or to suspension, reprimand [...] probation concerning, a license to practice a[...] healthcare profession or state or fede[...] 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 [X] 6.) Have you had any clinical privileges or oth[...] similar institutional authority suspended, restrict[...] or revoked for reasons <u>other than failure [...] maintain records on a timely basis or to atte[...] staff meetings?</u>

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

[ ] Check this Box if you have NO principal Practice address.

Street: 711 East Hollister Street
Street:
City: Cincinnati State: OH Zip Code: 45219
County: Hamilton

REQUIRED:
[redacted]
SOCIAL SECURITY NUMBER

Date Posted: 4/4/2006 4:01:18 PM

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

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

License Information

License Number	35.048288
License Name	KATHERINE HEWITT
Email Address	

Fees

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

Specialty Codes

1. Please select one specialty from the field below

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

   .... *{not Answered}*
3. Please select one specialty from the field below, if applicable.

   .... *{not Answered}*

CME-Physicians

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

   .... YES

Discipline

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

   .... NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

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

   .... NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints

against you?

.... NO

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

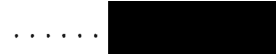
.... NO

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

.... NO

Social Security Number

1.

...... 

Nurse Collaboration Info

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

.... NO

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

.... *{not Answered}*

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

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

Date Posted: 4/8/2008 10:09:09 AM

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

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

Address Information

BUSINESS ADDRESS	71 E Hollister Street Cincinnati, OH 45219 Hamilton County United States of America 513-723-0909 drskkh@one.net
CREDENTIAL MAIL ADDRESS	71 E Hollister Street Cincinnati, OH 45219 Hamilton County United States of America 513-723-0909 drskkh@one.net
MAIN	6351 Cambridge Avenue Cincinnati, OH 45230 Hamilton County United States of America 513-232-4189

License Information

License Number	35.048288
License Name	KATHERINE HEWITT
Email Address	drskkh@one.net

Fees

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

Specialty Codes

1. Please select one specialty from the field below

   .... GYNECOLOGY

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

   .... *{not Answered}*

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

.... *{not Answered}*

CME-Physicians

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

.... YES

Discipline

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

.... NO

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

.... NO

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

.... NO

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

.... NO

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

.... NO

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

.... NO

Social Security Number

1.

......

Nurse Collaboration Info

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

.... NO

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

.... *{not Answered}*

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

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

Date Posted: 6/8/2010 12:30:25 PM

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

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

Address Information

BUSINESS ADDRESS

5777 Kellogg Avenue
Cincinnati, OH 45230
Hamilton County
United States of America
513-232-3232

CREDENTIAL MAIL ADDRESS

5777 Kellogg Avenue
Cincinnati, OH 45230
Hamilton County
United States of America
513-232-3232

License Information

License Number	35.048288
License Name	KATHERINE HEWITT

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

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

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

.... NO

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

.... NO

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

.... NO

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

.... NO

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

.... NO

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

.... NO

Social Security Number

1.

Nurse Collaboration Info

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

.... NO

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

.... *{not Answered}*

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

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

Date Posted: 7/18/2012 2:58:11 PM

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

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

Address Information

BUSINESS ADDRESS	5777 Kellogg Avenue Cincinnati, OH 45230 Hamilton County United States of America 513-232-3232 riversidegyn@yahoo.com
CREDENTIAL MAIL ADDRESS	5777 Kellogg Avenue Cincinnati, OH 45230 Hamilton County United States of America 513-232-3232 riversidegyn@yahoo.com
MAIN	6351 Cambridge Avenue Cincinnati, OH 45230 Hamilton County United States of America 513-232-4189 riversidegyn@yahoo.com

License Information

License Number	35.048288
License Name	KATHERINE HEWITT

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

   .... GYNECOLOGY

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

   .... *{not Answered}*

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

   .... *{not Answered}*

CME-Physicians

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

   .... YES

Discipline

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

   .... NO

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

   .... NO

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

   .... NO

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

   .... NO

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

   .... NO

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

   .... NO

Social Security Number

1.

   ......

Nurse Collaboration Info

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

.... NO

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

.... *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

.... YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

.... 35-39

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

.... 5-9

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.)

.... 5-9

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

.... 1-4

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

.... 0

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

.... 1-4

Clinical - Practice setting

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

.... 5-9

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

.... 5-9

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

.... 0

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

.... 1-4

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

.... 1-4

Workforce Counties

1. Enter the first zip code:

. . . . 45230

2. Enter the first county:

. . . . Hamilton

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

. . . . 2-5

3. Multi-specialty Group

. . . . N/A

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

. . . . NO

Workforce Language Question

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

. . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . NO

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: 7/8/2014 10:46:47 AM

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

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

Address Information

BUSINESS ADDRESS	5777 Kellogg Avenue Cincinnati, OH 45230 Hamilton County United States of America 513-232-3232 bariversidegyn@yahoo.com
CREDENTIAL MAIL ADDRESS	5777 Kellogg Avenue Cincinnati, OH 45230 Hamilton County United States of America 513-232-3232 bariversidegyn@yahoo.com
MAIN	6351 Cambridge Avenue Cincinnati, OH 45230 Hamilton County United States of America 513-232-4189 bariversidegyn@yahoo.com

License Information

License Number	35.048288
License Name	KATHERINE HEWITT

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

   .... GYNECOLOGY

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

   .... *{not Answered}*

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

   .... *{not Answered}*

CME-Physicians

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

   .... YES

Discipline

1. **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.

. . . . . .

Nurse Collaboration Info

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

   . . . . NO

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

   . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

   . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

   25-29

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

   1-4

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

   5-9

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

   0

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).

   20-24

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

   1-4

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:

.... 45230

2. Enter the first county:

.... Hamilton

3. Enter the second zip code:

.... 45219

4. Enter the second county:

.... Hamilton

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

.... 2-5

3. Multi-specialty Group

.... N/A

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

.... NO

Workforce Language Question

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

.... NO

ABMS Certified

1. Are you certified by an ABMS Board?

.... YES

ABMS Specialty

1. Choose specialty from the dropdown list.

   .... Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

   .... *{not Answered}*

3. Choose specialty from the dropdown list.

   .... *{not Answered}*

NPI number

1. Please enter your current NPI number

   1952499626

DEA number

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

   .... AH3224045

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: 9/12/2016 2:53:23 PM

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

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

Address Information

BUSINESS ADDRESS	8240 northcreek dr suite 4100 Cincinnati, OH 45236 Hamilton County United States 513-853-7555 craw10s1@netscape.net
CREDENTIAL MAIL ADDRESS	8240 northcreek dr suite 4100 Cincinnati, OH 45236 Hamilton County United States 513-853-7555 craw10s1@netscape.net
MAIN	6351 Cambridge Avenue Cincinnati, OH 45230 Hamilton County United States 513-232-4189 craw10s1@netscape.net

License Information

License Number	35.048288
License Name	KATHERINE HEWITT

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

   .... GYNECOLOGY

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

   .... GYNECOLOGY

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

   .... GYNECOLOGY

CME-Physicians

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

   .... YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

   .... NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

   .... NO

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

   .... NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

   .... NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

   .... NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

   .... NO

Social Security Number

1.

. . . . Redacted

Nurse Collaboration Info

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

   . . . . NO

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

   . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

   . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

   35-39

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

   0

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.)

   5-9

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

   0

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).

   30-34

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

   1-4

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:

. . . . 45236

2. Enter the first county:

. . . . Hamilton

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

. . . . 2-5

3. Multi-specialty Group

. . . . N/A

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

. . . . 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?

. . . . NO

NPI number

1. Please enter your current NPI number

. . . . *{not Answered}*

DEA number

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

. . . . ah3224045

OARRS Registration

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

. . . . YES

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

. . . . YES

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

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

Submission Date and Time: 9/20/2018 1:07 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
KATHERINE
Middle Name
DENISE
Last Name
HEWITT
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
9/24/1954
Email Address
craw10s1@netscape.net
Phone Number
5138537555
Other Phone Number
(513) 232-4189

Additional Information

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

Do you have other aliases?
No Response
What is your gender?
Female
What is your ethnicity?
No Response
In which country were you born?
United States
In which state were you born (if United States)?
Ohio
In which city were you born?

springfield

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.

6351 Cambridge Ave
Cincinnati
OH
45230-1973
United States

License Public Address

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

8240 northcreek dr suite 4100
Cincinnati
OH
45236
United States

Military Service

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

Have you served in the military?
No
Has your spouse served in the military?
Not Applicable
I declined to answer these questions

Secondary Email Recipient

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

Secondary Email Address:

Specialty Tracking Component

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

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 - No

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

Question - Primary NPI Number
Answer - 1952499626

Question - Primary DEA Number
Answer - ah3224045

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 - No

Question - On average, how many hours per week do you work under the license for which you are currently applying or renewing?
Answer - 40

Question - How many locations are you currently working in that require the license you are renewing?
Answer - 1

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 - Trihealth, Cincinnati, Ohio

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 - Not specified

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 - 9/20/2018 1:07 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
KATHERINE HEWITT
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.